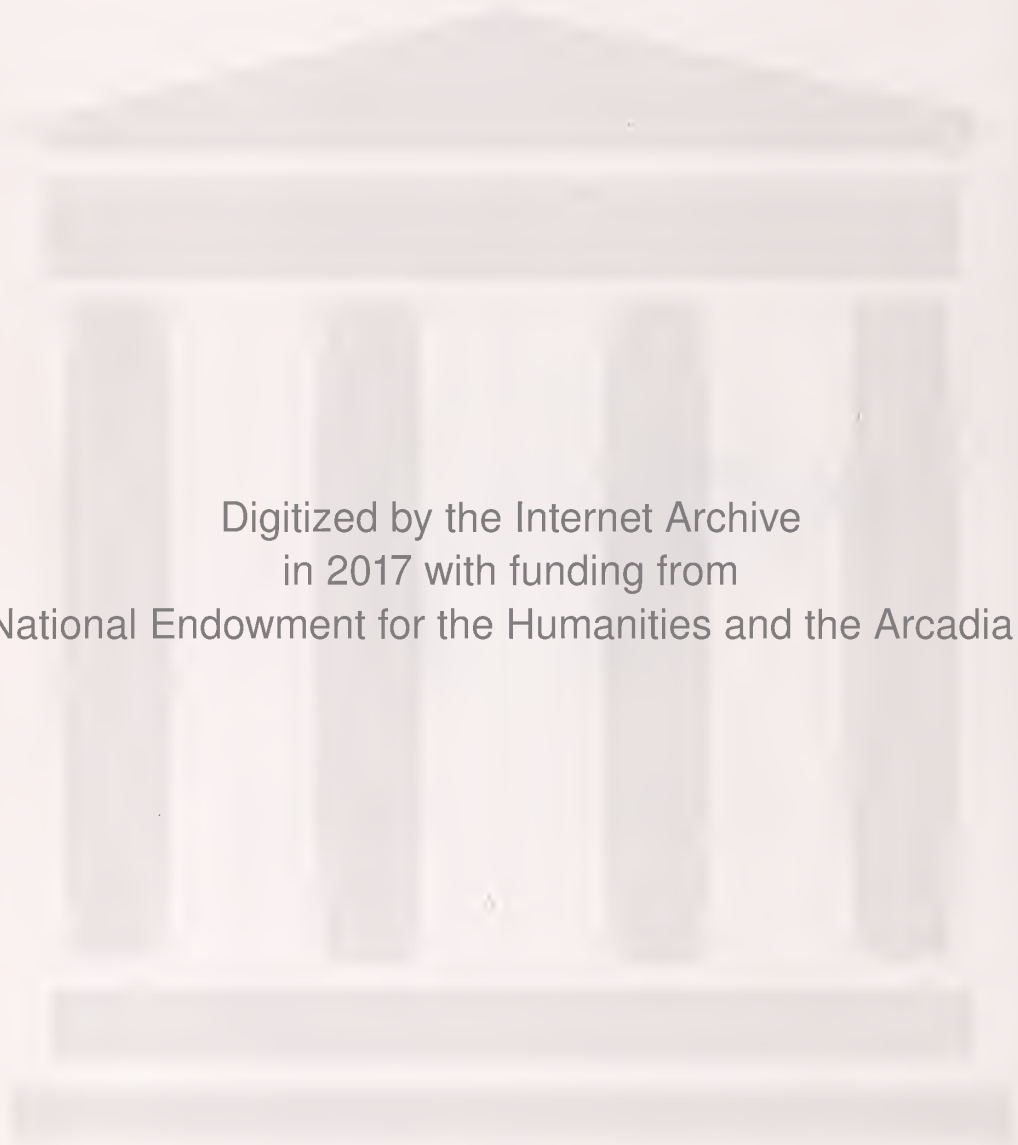


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SOUTH DAKOTA JOURNAL



MEDICINE *and* PHARMACY

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION
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JANUARY • 1963

V.16 #1



sign of infection?



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Ilosone® is available in three convenient forms: Pulvules®—125 and 250 mg.*; Oral Suspension—125 mg.* per 5-cc. teaspoonful; and Drops—5 mg.* per drop, with dropper calibrated at 25 and 50 mg.

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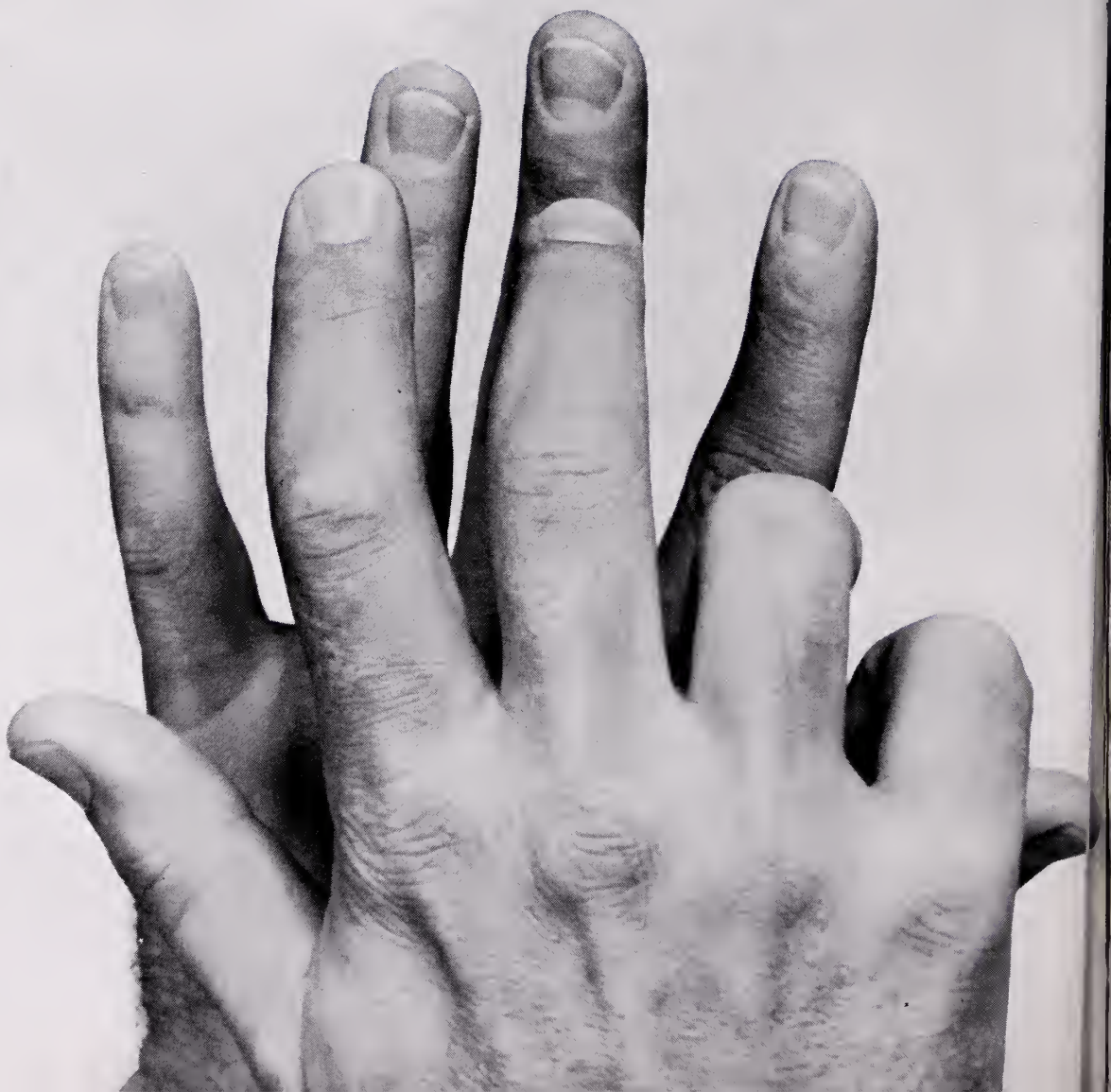
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in severe respiratory infections refractory to other measures.

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(chloramphenicol, Parke-Davis)

for established clinical efficacy against susceptible organisms[1-]



In Friedlander's Pneumonia[3,13]

Although the prognosis in Friedlander's pneumonia is poor, treatment with CHLOROMYCETIN has shown a good response when susceptible strains of *Klebsiella pneumoniae* are incriminated.

In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

Because the invading organism is usually sensitive to CHLOROMYCETIN, this agent is generally effective in pneumonias caused by *H. influenzae*.

In Staphylococcal Pneumonia[1-8,13]

CHLOROMYCETIN continues to remain effective against many resistant strains of staphylococci, and—alone or in combination with other antibiotics—should be considered when other antistaphylococcal drugs are ineffective.

In Acute Epiglottitis[4,10,11]

This condition is most often caused by *H. influenzae*, most strains of which are sensitive to CHLOROMYCETIN. Therapy should be instituted at once, since the disease may progress from the first symptoms to a severe respiratory obstruction in four to six hours.

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Because of its broad-spectrum activity, CHLOROMYCETIN is often effective in pneumonias caused by sensitive strains of *Aerobacter, Proteus* of various species, *Paracolobactrum,* and other gram-negative pathogens encountered with increasing frequency in serious respiratory tract infections.

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References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

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THE SOUTH DAKOTA

JOURNAL OF MEDICINE

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JOURNAL OF THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION, THE SOUTH DAKOTA PHARMACEUTICAL ASSOCIATION AND THE SIOUX VALLEY MEDICAL ASSOCIATION

Volume XVI **January, 1963** **Number 1**

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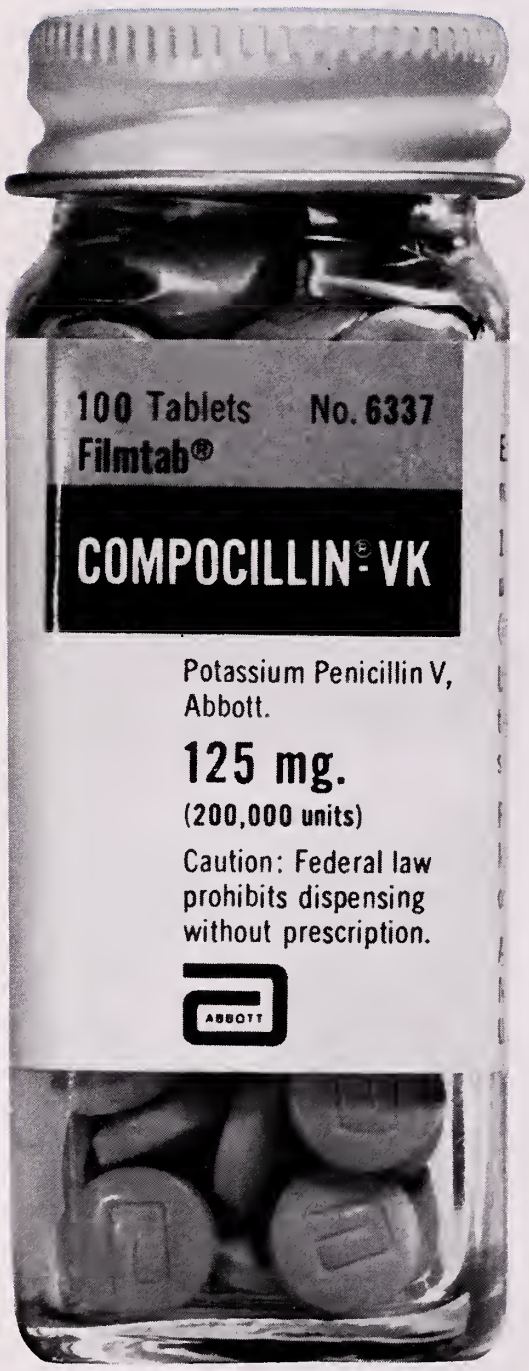
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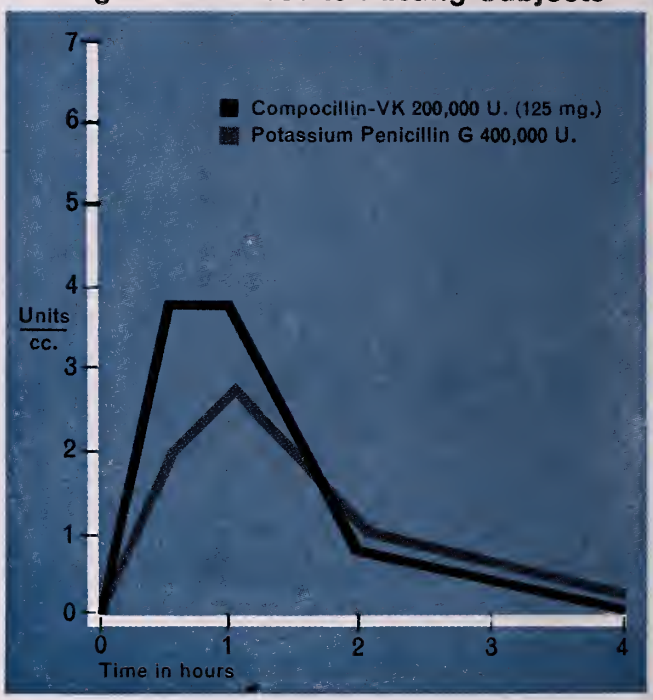
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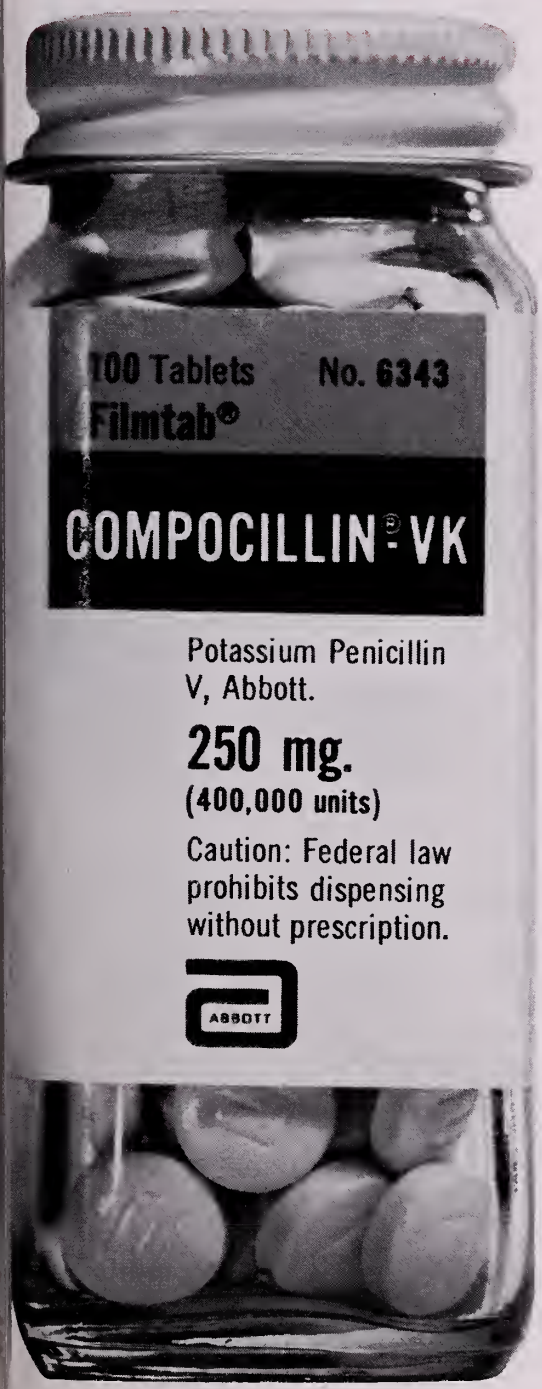
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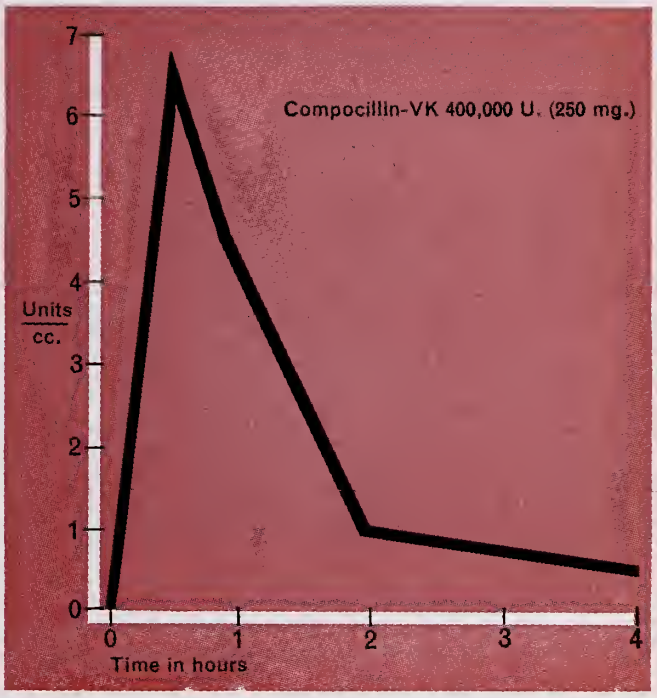
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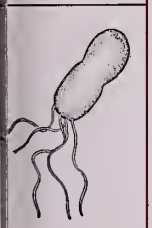


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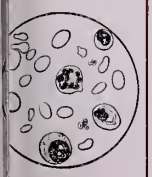
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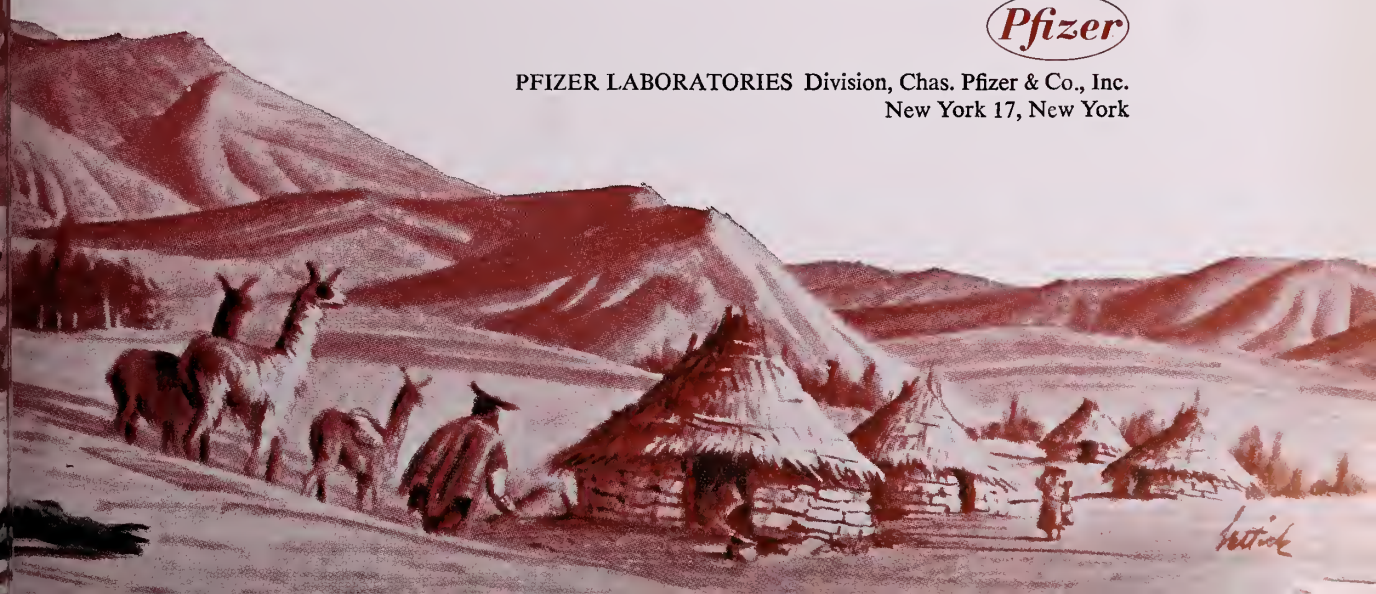


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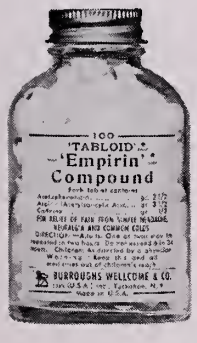

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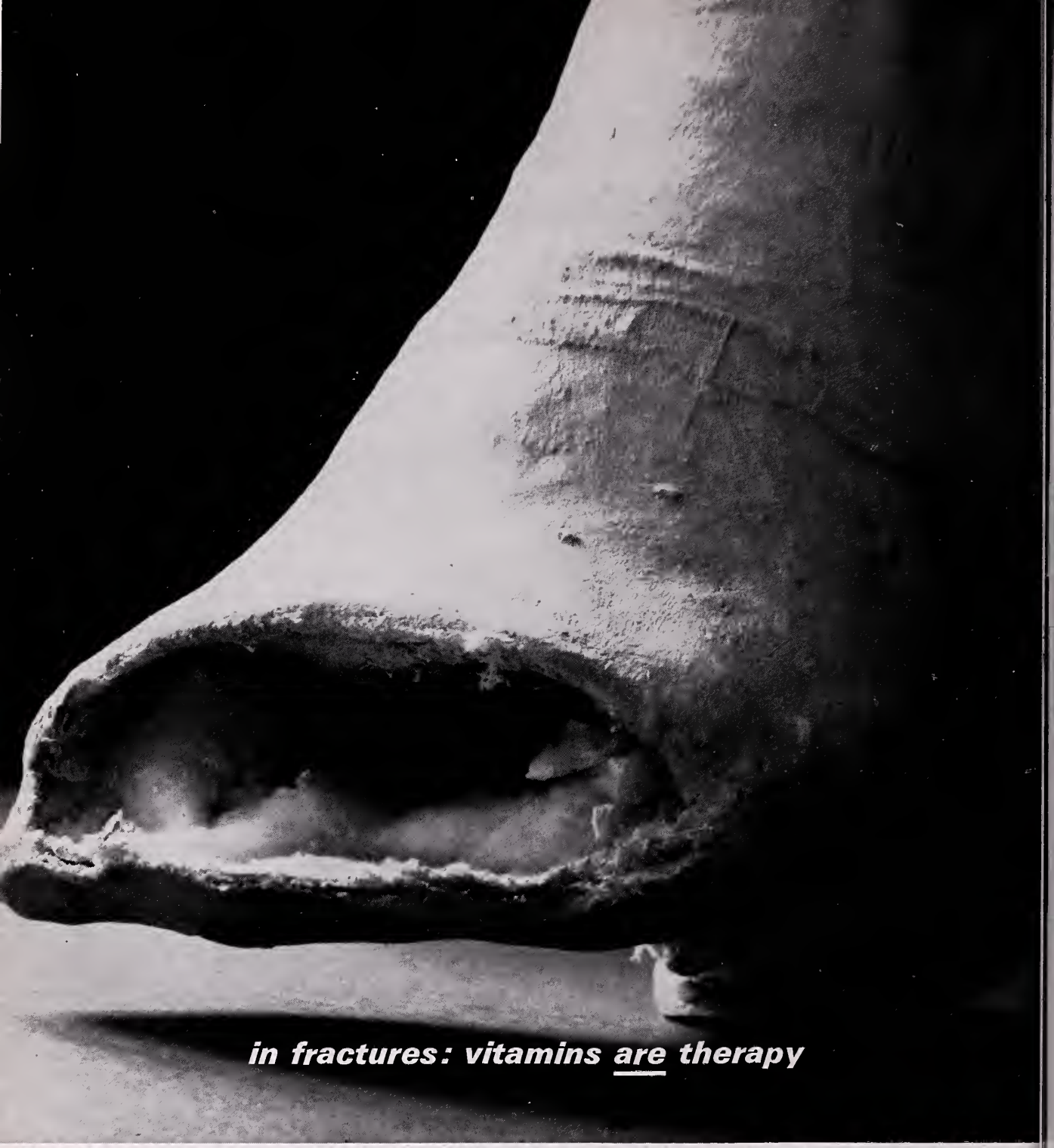


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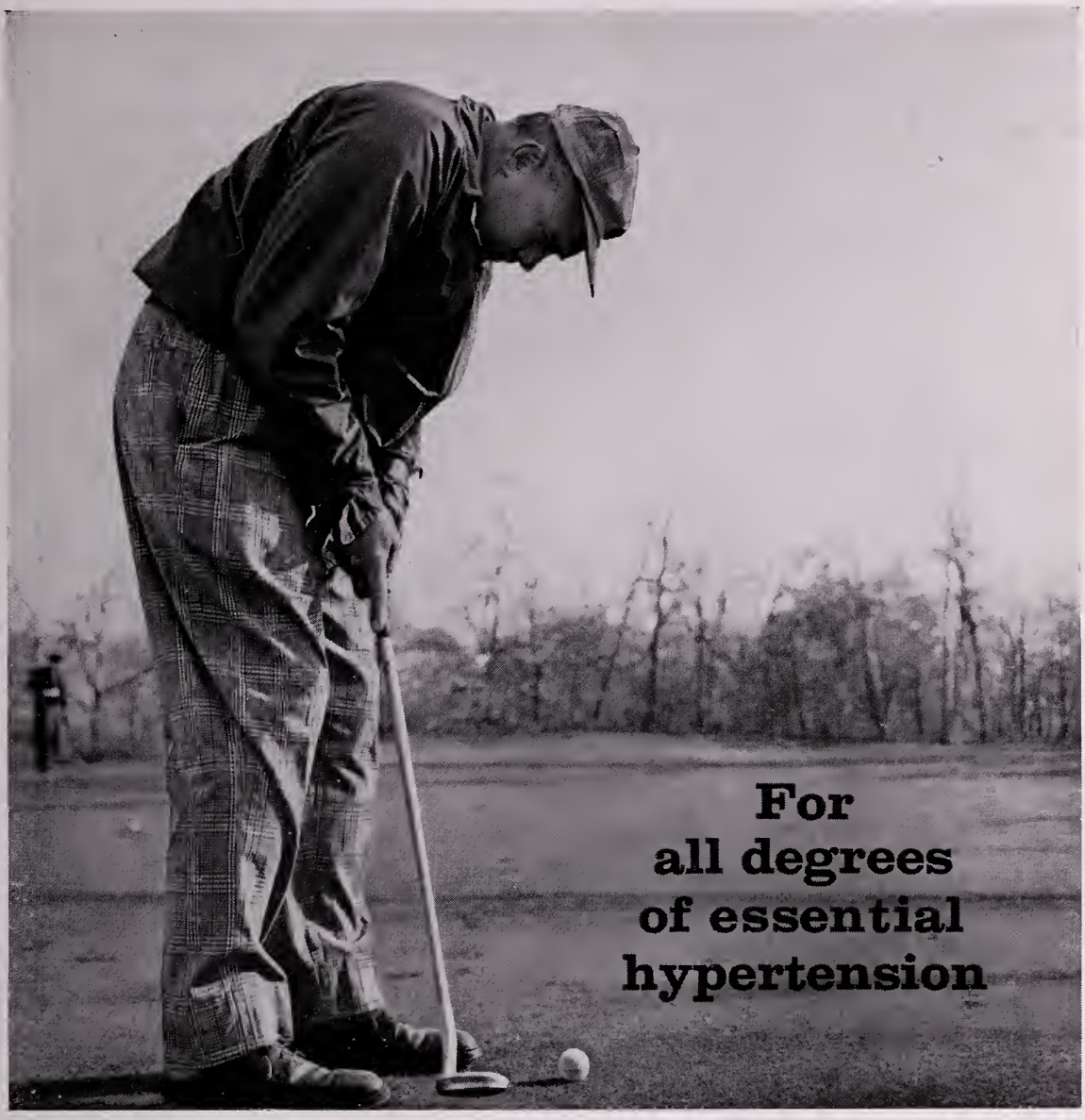
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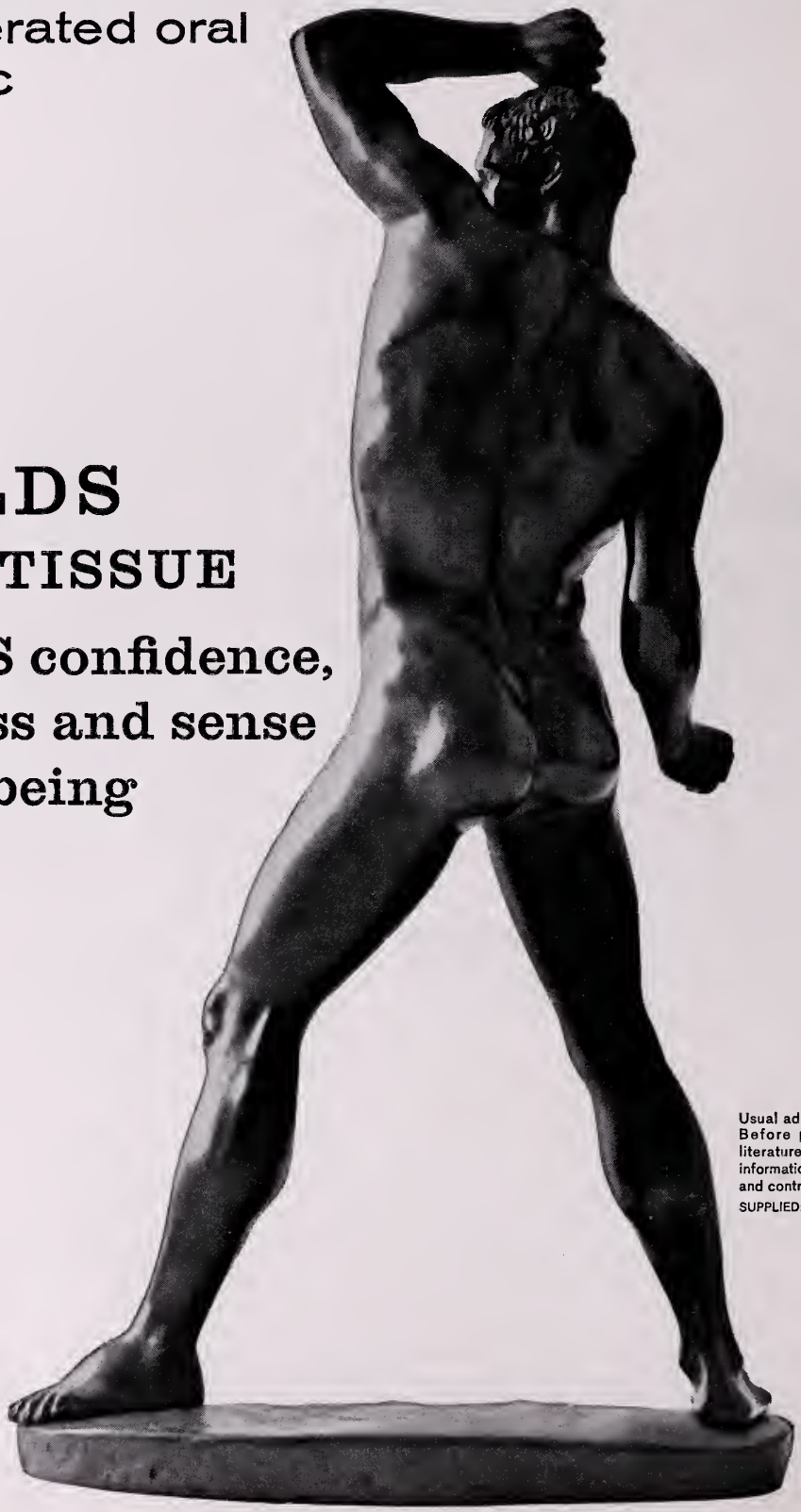
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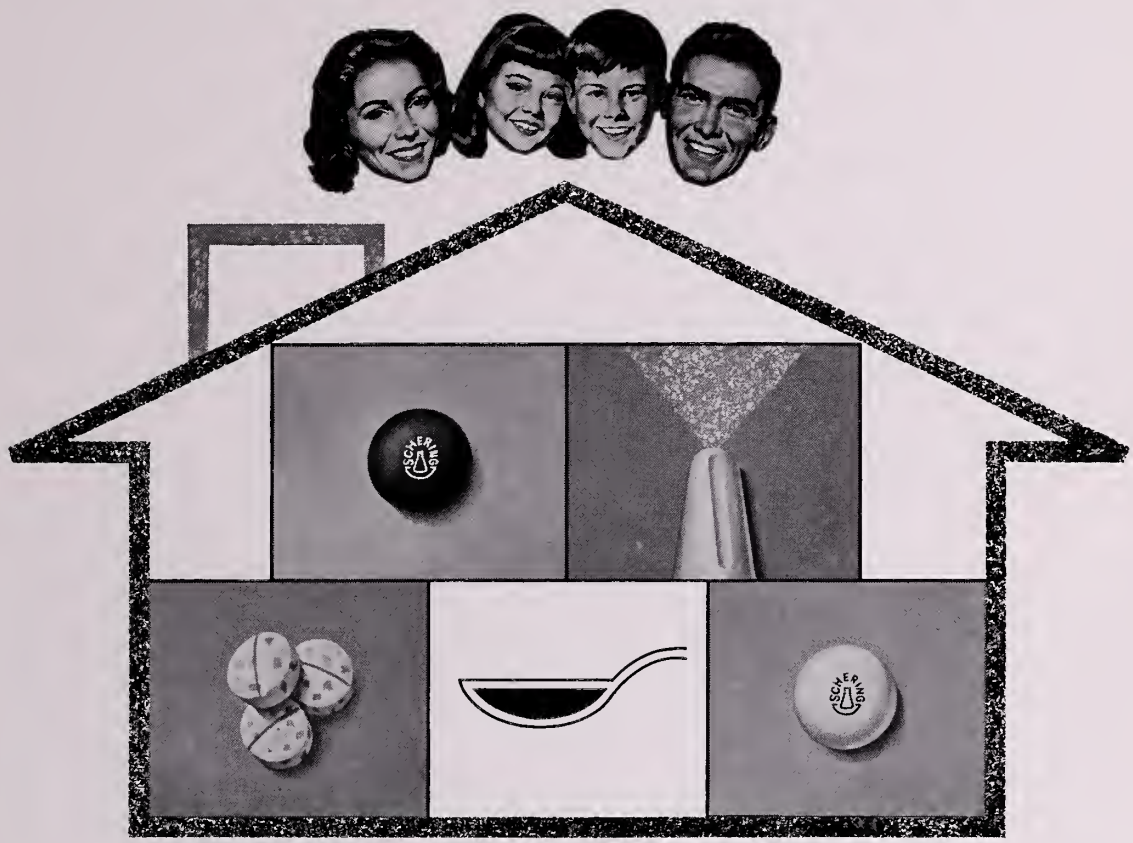
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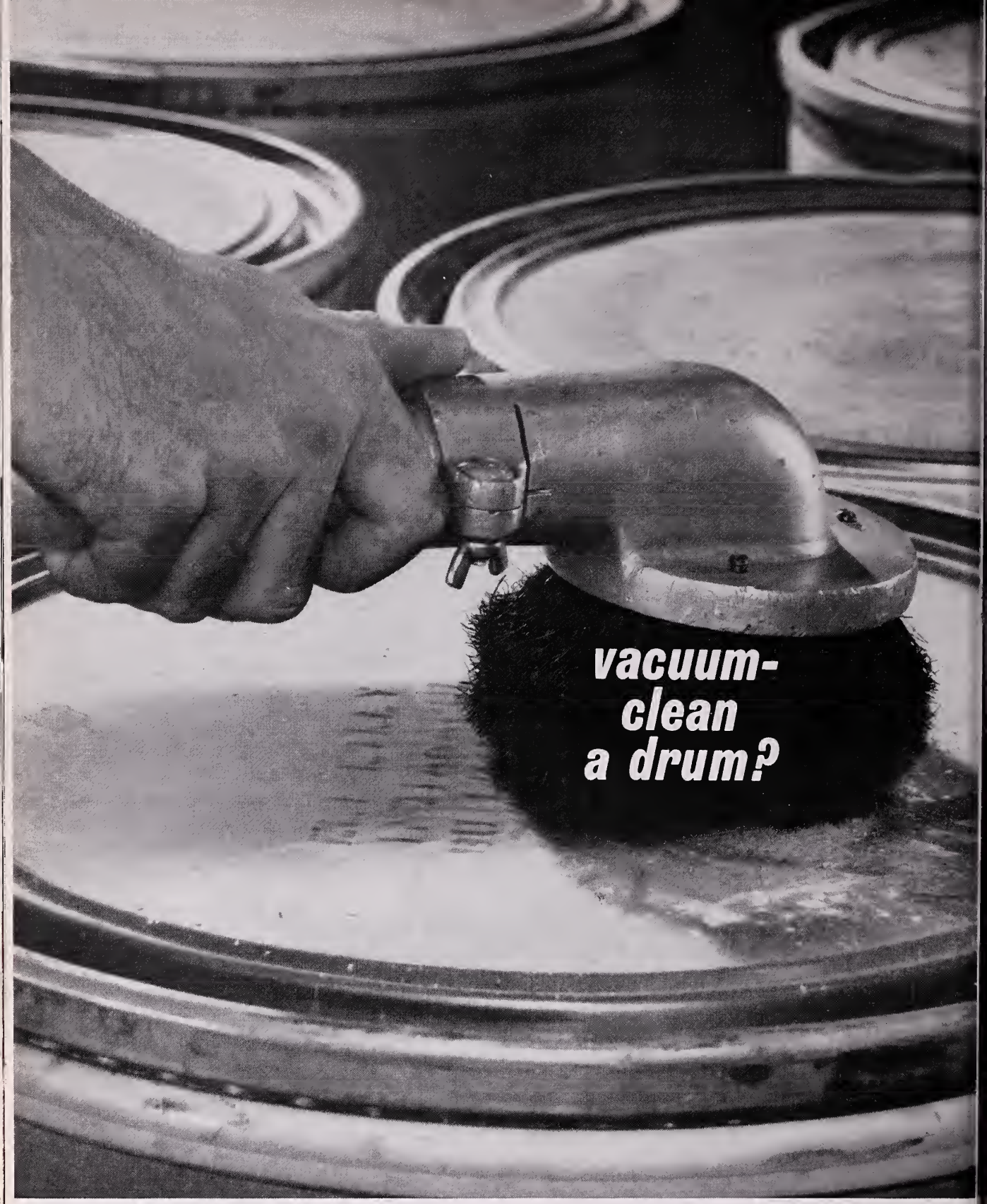
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His Excellency's Loyal Opposition Speaks

By

Roy C. Knowles, M.D.

Sioux Falls, South Dakota

I like this British way of describing opposition which allows for a definitive difference of opinion without the connotation of treachery, treason, or defection.

There occurred in Sioux Falls recently a phenomenon which reminds us that the processes of social, political, and economic evolution must be recognized.

Through the history of the past twenty-five to thirty years this Country has steadily, although relatively slowly, turned in the general direction of socialism or a socialistic form of government. By this designation I do not mean to imply that our government has fallen into the hands of people who are not American or who are anti-American in their approach. I simply mean that the governmental philosophy has gradually changed so that the ideas, the socialistic ideas, which have been expressed for long periods of time have gradually become acceptable.

Such evolutionary change is doubtlessly necessary. Whether the direction at any one moment is proper or best is for the total of the American people to decide. Our government, and our way of doing things, must gradually change as the demands the American people place upon government gradually change.

The tremendous population increase, the tremendous changes in our economic and social life require that things be different. Among the things which must be different is government.

Though we may acknowledge that there are changes and that there will be changes

and that changes are necessary, it still becomes our responsibility to raise voices in objection when the direction of the change appears to us, in all honesty, to be disadvantageous to the total American public. When changes appear to be directed toward a certain segment of the population or directed to help a certain segment of the population even though in the long run it may be detrimental to a much larger segment, then we must raise our voices to protest.

Were this Country small and of low population as it once was, an almost pure democratic form of government would be the ideal. The more the democratic processes can be preserved in spite of growth and during the normal evolution the better the over-all results for the country.

The essence of democracy is the freedom of the individual. This, of course, is not the kind of freedom one speaks of as anarchy where there are no rules and regulations. In democracy there are very rigid and very intensely required restrictions. One must practice his own independence only as he is to permit others to be equally independent. This essence of democracy, this freedom of personal expression, is the portion which must be most intensely and sacrificially preserved. Forms of government, in the sense of ritualistic methods of carrying out the functions of government, are of little or no importance. In some religious groups, form seems to take precedence over the basic beliefs and rules. This same phenomenon can occur in government. It is possible to make it to be more important that we do things a certain way rather than that we achieve a desirable goal or desirable end.

ADMINISTRATION ACTIVITY IN SOUTH DAKOTA

There appeared in Sioux Falls recently a young man who represents the point of view of our present national Administration. He came to Sioux Falls to speak to a closed meeting concerning a certain piece of legislation proposing to aid the elderly portion of our population by an "insurance" program under the Social Security system.

It is an interesting observation that this meeting was attended largely by people who support the idea of Social Security legislation and the inclusion of Medical Care for the Aged under the Social Security system. Yet the purpose of the meeting was to instruct these same people concerning what they were supporting. It is interesting that they came there intent on supporting a program which they did not understand and which they had to have explained to them. Their support was there before the explanation and understanding.

The man who represented the Administration's point of view handled himself very ably; he showed a considerable ability to answer questions which were directed at him; he showed that he had been well-drilled in the answers. He had also been well-drilled in trying not to antagonize the opposition. He showed considerable skill in appealing to the needs of certain specific groups. For example, he emphasized that the present legislative effort on the part of the Administration is directed only at hospitalization, nursing home care and home care of the aged. He emphasized that the program does not include medical care. The physician-patient arrangements would remain in their time-honored position. This is a clever kind of gambit which will result, of course, in gaining support from the hospital administrators and the various Boards of Directors. It is quite easy to understand why this would gain support because these people, many of whom are voluntary in their contributions, spend much of their time trying to overcome financial deficits. It is easy to say to these people that since hospital expenses for the aged will be paid the administrators will no longer have to worry about that particular part of their income. The fact that this particular part of the income is a relatively small part, in its unpaid component, is not taken into consideration. Likewise, this appeal will strike a responsive chord in the hearts of the people who are attempting to force nursing homes to be adequate. The already adequate nursing homes will welcome such a program because again the financial aspects promise to be secured.

THE "INSURANCE" ANGLE

This meeting got itself into the usual discussion concerning whether or not the program as planned is "insurance." A rather clever arrangement has been made which makes it so the proposed situation will appear to be an insurance program. The monies will be collected for several months in advance of

the actual beginning of the program; therefore, there will be a reserve amount of money available, first, for hospital and later, as the program matures, for nursing home care and then finally for home care. The money collected will then appear to be a reserve against which claims may be applied. This is supposed to remove the original weakness in the Social Security Program which caused many to complain that the Social Security Program is just another form of taxation. Actually, if one accepts a simple definition, the reserve will be there and this new program will fit the classification of insurance. However, there is a change or a difference from what you and I understand as insurance. In a matter of personal insurance we put into the program our own money; we put this money there in advance of our anticipated need for it. The people who provide the insurance coverage, the company itself, also deposits money in order to have a reserve against which claims may be drawn. In the case of Social Security, the people who will be drawing against this reserve will not be the people who put the money there in the first place. The aged who will now be claiming protection under this new legislation will not have contributed money to the program.

However, I think it is only fair to assume that our Country is leaning in the direction of providing protection for elderly people. There are many reasons for this, some of which are not honorable, but this appears to be the direction our Country is moving. The question we must raise concerns whether this particular proposal offers to the American people the program which will be best for them and which will best provide protection to the very essence of democracy, that factor of personal freedom.

At this same meeting the Administration's representative did what is commonly done when one attempts to avoid a rather obvious point. He overdid it. He was asked the question how one could answer the question of whether this present Administrative program is socialized medicine. He immediately claimed that this is not socialized medicine nor is it a toe-hold in the door which will ultimately lead to socialized medicine, and yet he immediately fell into his own trap by saying, "Let's look back at the history." He then went back to the Wagner, Murray, Dingell Bill of the 1930's. He admitted this was a socialized medicine program; this was defeated and defeated and repeatedly defeated because the American people did not want a socialized medicine program. He then moved down the course of history to some of the more recent legislative efforts, all of which were defeated. And then he moved down to the present Administrative program. Thus, he pointed out the unbroken line between a strongly and admittedly socialized medical approach and the present approach. He simply admitted that the Administration or successive administrations in their efforts to bring about a more intensely federalized and socialized program have gradually stepped back testing step-by-step to see what the people of this Country will accept. They now feel that they have a degree which will be acceptable. The logical conclusion is that, having accepted this degree, the American people would later then be willing to accept a reverse trail up the same road to socialized medicine.

In our most recent Presidential campaign both of the major party candidates emphasized that they were students of history. (I hesitate at this point to go on because in some of the recent interchanges between proponents and opponents the opponents were told that they were not eligible to speak against a certain subject because they did not happen to be trained social workers or social scientists. One wonders in a situation such as ours in a Country such as ours if one must need be an authority in a particular field in order to have a knowledgeable opinion in a particular field. Thus it is with history.) All of us have studied history; most of us in this Country, which provides such a wide and general program of education, have studied ancient history and we have seen the same lessons that our Presidential candidates were drawing from. We have recognized that history has taught us that when certain things happen to civilizations these civilizations decay. One of the most important of these negative things which can happen to civilizations is that the people be forced into a situation of becoming dependent upon the government. We can speak of people being placed on the dole, we can speak of the government having to provide breadlines or we can become much more subtle, but nevertheless effective, by

simply having people become dependent upon the Federal Government for their security.

This leads to a discussion which is a very difficult one to handle. There is no question that the Administration and the loyal opposition both want for this Country that which is best. There is no need to regret the fact that there are opposing opinions; indeed, the very fact of opposing opinions makes it necessary that we search diligently to be sure which opinion will ultimately gain for the mass of the Country the greatest good.

However, certain of the elements about which we are "fighting" at this moment lend themselves to very sentimental, emotional misusage. It is very easy for people who are interested more in gaining their own point to make issues out of things which are not issues. For example, it is very easy to make it appear that the loyal opposition dislikes aged people and does not want to have the aged people get for themselves that which is theirs. It is very easy to indicate that the ones who oppose a particular point of view are representative of an extreme element within the government. This is so whether we are speaking of the extreme left or the extreme right.

TECHNIQUES

There is a technique which was used in the White House Conference on Aging in 1961 which has become a rather prominent one and one to decry. People who want to support a certain point of view need only point out that the opposition is using an unpleasant, undemocratic method in order to put the opposition on the defensive and weaken the position. Right at the present time the mental health movement finds itself stymied here and there by remarks from certain groups or certain organizations indicating that in the opinion of the leaders of these groups the Mental Health Association or various mental health groups are attempting to brainwash people and are, therefore, "probably" Communistic. So fearful are we of this kind of statement that we then cause people who are attempting to do the best they can, to defend themselves against accusations and thus exhaust the energy that they do have available for the work which is to be done.

In the White House Conference on Aging there was a big furor raised about the supposed fact that the opposition to Social Security methods of handling medical problems of the aged had packed the meeting. In actual fact, the packing was done by the accusers. It was not so much that the total number of people were packed by the Social Security supporters; it was that the special committees or special discussion groups were packed and then rules were promulgated which made it so that only those particular groups could vote on certain things. Other groups had to vote on other things. This, of course, made it very easy for the proponents of Social Security measures to come out of the White House Conference on Aging with what appeared to be a very strong, positive support for the Social Security financing program.

Techniques of this kind have been used for long periods of time. They obfuscate the real issues; they besmog everything that they touch, and the end result is that people who are not intimately involved in the discussions or in the disputations can only make a decision about who makes the most fog or who ultimately appears to be in the most disrespectable position.

We cannot afford this kind of approach; it may be very good political technique, but it results in very bad things for our Country.

A LOOK AT HISTORY

Let me turn back to history just a moment and point out one observation. This will be a very unpopular observation, but I think it is, nonetheless, an accurate one. It was not long ago in the early industrial evolutionary time of our Country that the effort to educate our children was a very slipshod thing and a great many children were forced into sweatshop circumstances of working. They would be put to work at very early ages and be made to work for long, long hours. The result, of course, was illness and early death and a very sad and unhappy situation. A country such as ours would not tolerate this kind of situation once it was brought to public view. Therefore, the movement began to get the children out of the sweatshops and to get the children into situations in which they could go to school. All of this, to this point, is very good; indeed, if we were back in that situation I am sure that most of us would very gladly support any move to correct such a sad, shameful condition.

However, certain parts or certain results of

this corrective effort have had negative results in the total picture of our Country. Not only did we take children out of the sweatshops but we took children out of any kind of constructive labor. One can find certain contradictions to this; for example, we didn't stop children from sacking groceries in a grocery store; we didn't stop children from delivering newspapers. But when it comes to really constructive, expressive labor, we took all children out. We took children out who could not satisfactorily complete a formal education. We made it necessary for them to sit for long years in classes; we made it so they could not go to work instead.

Why did we do that? Why did we swing so far in this one direction? We did it because the movement to get the children out of the sweatshops, the highly emotional movement to get the children out of the sweatshops, lent itself very easily to the cause of those who selfishly wanted to hold all jobs for themselves. Now I can understand the reasoning behind this, and I am not criticizing the over-all because I am sure that the point of view can be very well substantiated. I am trying to point out here that certain of our constructive methods lend themselves to the service of unconstructive people and finally destructive results. Because the adult wage-earner desired for himself, or because his leaders took the opportunity to make a point of his desiring, certain job security for himself, all children were pushed out of the labor market. Now we know some of the results. We look around for certain of the causes of juvenile delinquency. We very seldom talk about the fact that children are not allowed to work. We don't talk about that because it would be unpopular, but at the same time the fact still remains that we have contributed to the restlessness, to the lack of self-esteem, to the purposelessness of certain of our young people by denying them the opportunity of expressing themselves through the medium of meaningful work.

Suppose we take the moral from this bit of American History and apply it to our present situation with the care of the aged.

THE AGED

There are a great many elderly people who do not have to be relegated to a shelf. They can continue to be very productive and very worthwhile. One of the ultimate results of our present move, or of the present efforts, will be that all people beyond the age of 65 will have to retire. And then it will be that all people beyond the age of 60 will have to retire. And then it will be that all people beyond the age of 55 will have to retire. Go back to the problem of children. The first laws had it that the early teenagers could not work, then they gradually crept up and crept up and crept up so now it's almost universal that a child must be at least sixteen before he works and most kids cannot get a reasonable job before they're eighteen.

Each time there is some kind of a squeeze on the middle economic group, the ones on either end have to be shoved out. The money which will go into the Social Security Program must come from the taxpaying group. This taxpaying group is, by and large, the middle aged group. This middle aged group, put under additional squeeze as is now planned, must then begin an additional push to reject the elderly and shove more and more onto the shelf.

And then a final point. The early history of every individual is that he once was extremely dependent. There was a time that each human being was a baby and completely dependent for his sustenance on a strong mother or father person. One of our very difficult tasks as adults is to lead the individual infant through his childhood and through his adolescence to get him eventually to a state that he can work as an honorable person in a condition of independence and freedom. We must get him to a point, not only that he can politically mouth the words that he has freedom of choice and that he has freedom of speech and that he has freedom of religion, but we must get him to the point that he can actually enjoy these freedoms, he can actually practice these freedoms. If our Country leans more and more in the direction of keeping our young people out of maturity and away from independence and if our Country continues to lean in the direction of earlier and earlier putting our elderly people into a state of retirement and dependence upon the Federal Government, we will find that it will be very much more difficult for the adults to try to inculcate in their children the very principles and very personality strengths which make it possible for them to celebrate the freedoms which should be theirs.

Not only will we deny to parents the right to build into their children a large core of individual freedom, we will increase a tendency which is always there in each of us to return to that which once was. Each of us finds it a very easy thing to fall back into a dependent relationship on other people, particularly on strong people or on people who propose to supply certain specific things we need. It will not be a difficult thing so long as the evolutionary process is allowed to go without being searched and examined. It will not be a difficult thing to gradually teach the mass of our people to remain in a state of dependency or to return to a state of dependency. Then we will have completely succeeded in doing what other countries are doing by a revolutionary process which we so thoroughly decry. We will have set up a dual class system, those who depend and those who dish out. The ones in the ascendancy will then have a total country of servants.

The picture as painted by the above paragraph sounds black. I do not propose to have the wisdom to see all that is coming in our future. I would like to believe in the over-all history of our Country. I would like to believe that most moves are made slowly and as they are required and in a way which benefits the total group. There is no question that this Country is better off than it used to be. It is my hope that by the combined efforts of the political group in power and the loyal opposition, by the combined efforts of the far-left and the far-right, by the combined efforts of the actionary as opposed to the reactionary the developments in our Country will cause the steady increase. There is no question that from time to time we tread upon certain small groups as we undertake to benefit the total mass. This we must do, this there is no turning away from, but we must be sure that what we are attempting to do will lead this Country up the road instead of down.

THE SOCIAL SECURITY APPROACH

I object to the Social Security method of financing for medical care, for hospital care, or for any other specifically designated service.

If it is to be accepted that the American people have decided that through a tax-supported method they are to provide financial security for themselves in their old age I feel the agency, Social Security or otherwise, should acknowledge this to be the full function. If American people make this decision, then the chosen agency should be so increased

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as to provide sufficient protection without specification. In other words, the amount of money available through the agency to the recipient should be large enough to make it so that he can take care of himself. If he denies himself by unwisely using that which is determined to be his, he has made his own result. Thus, we preserve for the individual his own individual right to control himself, to decide for himself, to live for himself, and even indeed, to die for himself. I do not believe this agency should have control whereby it could specify that portions of the money would be used for one thing or another. This method would conceive of the Federal government as a large piggy-bank from which each individual could withdraw his own savings at a specified rate but for an unspecified purpose.

Actually, I do not believe that the Federal government should function in this way — as a large banking service for the American people. I believe these banking services and insurance services should be utilized and purchased by the individual during his own lifetime. However, it may prove that the American people as a group do not agree. It may prove that the American people desire more Federal intervention. If this be their desire I hope it will not be because they think Uncle Sam is giving them something. Every dollar which goes full-circle from the tax-payer through Washington, D. C. and back to the tax-payer is considerably smaller when it comes to rest at home.

Returning to the specific subject of medical care or hospital care for the aged, it is my feeling that the Social Security mechanism should be dropped from the picture since it is so obviously a further step in the socialization of this country. In its stead I feel that the present plan of State and Federal matching of monies for provision of services is better. Thorough study may prove that some of the more recent proposals of tax-relief for those people who purchase insurance for themselves will provide greater incentive and ultimately greater protection. It most certainly will provide greater protection to a way of life in which the governed have guaranteed to themselves the perpetuation of the ideal individual freedom and government by the people.

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The Development Of Group Psychotherapy For Psychosomatic Manifestations In Various Existing Settings

By

Sylvia F. Sternlieb, M.D., (F.A.P.A.)

Aberdeen, South Dakota

Rather than attempt to describe the development of all aspects of each program as pioneering new trails in group therapy, I shall try to emphasize **outstanding variants** in each particular setting.

Historically, the development of groups for patients suffering with somatic symptoms has been important. In one of my studies as Section Chief at the South Florida State Hospital, Hollywood, Florida, throughout the years of 1958 and 1959, I formed a "class" of chronic hypochondriacal patients who were apparently not improving with conventional medical care. Since they had repeatedly visited all the hospital clinics, such as Fort Lauderdale, Hallandale and West Palm Beach, these patients could be readily selected by the weight of their charts — patients who chronically migrated from one clinic to another without relief or **termination.**

One finds these patients to be openly masochistically orientated. Their ego identification suggests the attitude, "if I suffer, I will be loved," or "as long as I am with symptoms, someone will show an interest in me."

A group of 25 or 30 of these patients was formed. Throughout sessions called "ward meetings" or "gripe sessions," the psychologist, the social worker, the nurse and the aides of this particular team were present as participants with myself as the leader of the team. I attempted, specifically, even though via the metaphor, to motivate some intellectual "understanding" of the relationship between their emotional attitudes and physical manifestations.

As a patient's symptoms improved, he would be graduated to the head of the class. The patients, desiring the leader's approval and the recognition of the group, found themselves competing through symptomatic improvement.

Similar patients were placed in **"open-end"** groups at the Jackson Memorial Hospital, Miami, Florida, in the research psychiatric unit under a well trained psychiatrist, myself being the researcher. **Why had the patients repeatedly returned to clinics which had not helped them?** It was found that the patients who had been on the hospital roles for many years had become dependent upon the institution for emotional needs and to return to a clinic, a symptom was necessary. Placed in a group, it was found that the patients transferred this dependency and could give up the symptoms. **Though symptom free, a patient was still eligible to return to the group, whereas, if free from symptoms, he would have to eliminate himself from other clinics, thus frustrating his dependency.**

In this setting, after the groups had been conducted for several months and the selection of patients was based upon ability to grow emotionally, more progress and in a different direction was made. Rather than exchanging symptoms for gratification of dependency needs, the approach was aimed at changes in the patient's **ego orientation.** In the beginning, there were many patients whose attitudes seemed to betray the belief, "if I suffer, I will be accepted." As treatment progressed, some patients began to compete with the therapist for leadership, often challenging her in a provocative way. There was evidence of ambivalence and guilt over this competitiveness. (It is noteworthy to know that any group in question was constituted of both male and female patients in about equal numbers.)

The therapist had to be careful during this stage so that she saw this behavior as a substitutive type of ego orientation replete with hostility. Otherwise, there was danger of reacting to the patients' provocativeness. The least reaction on the part of the therapist during this phase can threaten the patient to such a degree that he will quit the group before there is a chance to work out his fearfulness. However, if this competitive phase is dealt with successfully, the patient can often be seen to develop to an imitative type of ego identification. Again the patient is behaving like the leader. But, instead of trying to be a substitute for the leader by "killing her" (the way in which the unconscious mind perceives it at the earlier level), the patient, at this new orientation learns that he can be **like the leader** without necessarily eliminating her. Relieved of his hostility and death fantasies, the patient is freed of his guilt and ambivalent behavior. He can more firmly adopt the therapist's attitude toward his symptoms and progress as far as **the therapist is prepared to allow him to do so.** Thus, a well trained therapist can help the patient beyond the point of exchanging symptoms for gratifying dependency needs or exchanging symptoms for acceptance.

According to Dr. Hugh Mullan,[1] leading psychoanalyst at the Institute of Psychoanalysis in New York, "The leader is somewhat more active in the terminal phase than he was during the middle phase of group psychotherapy." I also feel that group psychotherapy must be arbitrarily divided into phases for the convenience of the therapist. The patient is neither aware nor does he care what phase he is in as long as he is changing.

I prefer to identify a middle phase in order to communicate something tangible. I fix, in time, characteristic group psychotherapy dynamics which designate a beginning, a middle and a terminal period. The middle phase of group psychotherapy cannot exist without the period of preparation and the final or terminal phase. There is never a clear line of demarcation between phases. I have learned that this is particularly true in continuous groups where one patient is being introduced while another is preparing to leave (approaching the final or terminal period.)

This is readily understandable in the ongoing group process where the patients move at entirely different rates. We might expect this because the innate uniqueness of each group member determines to a large extent the onset and duration of his middle phase.

I would like to particularly emphasize the **advanced and terminal phases** in group psychotherapy. I want to make it clear from the beginning that I have never lead or even as

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[1]Mullan, Hugh, "The Psychoanalysis of Groups", **American Journal of Psychotherapy,** 3:1, 1952.

much as witnessed a whole group in an advanced or terminal phase of group psychotherapy. I do not think it can be done because I do not think that it exists. I would like to explain this as follows: Only one or more individuals have been so improved and no two have been so identical in sickness or in health that they could be said to be making exactly the same kind of progress.

To assume that a group advances toward termination "en masse" is to antropomorphise the group — to give it a unity and homogeneity which it does not, in fact, possess. This homogenizing of the group has led to an obscuring of individual differences, to a disregard for the uniqueness of each patient's pathology. With regard to the advanced phases in group psychotherapy, I refer only to the individual in interaction and not to the whole group, because **no group proceeds to termination as a group.** I did a survey[2] of psychiatric problems at outpatient clinics with corresponding centers at Huron, Mitchell and Madison throughout the years of 1955, 1956 and 1957. One of the goals of these clinics was to relieve the general hospitals of the increasing numbers of repeat visits as well as to "screen" the admissions to the State Hospital in Yankton. Primarily, these patients suffered loss of time from work with little permanent relief.

Development of Group Therapy

These patients were placed in a group for study. The failure of other attempts by outpatient clinics to help them was emphasized to them as was the recognition that we were investing efforts in endeavoring to find other ways to serve their needs.

As the discussions proceeded, it soon became evident that many of the patients who had been frequent visitors at the clinic were women in their late forties and early fifties who were living alone. Many had never married and all of them had few family ties. Many were immigrants who had devoted their lives to work without enjoying other interests. There was **little** to support them through this difficult period of life. A few physicial symptoms associated with menopause had introduced them to the **clinic.** Here they found interest and care which was new to them. Even after menopausal symptoms might have disappeared, I traced some patients who found the interests of the "help team" so gratifying that other symptoms brought them back. This happened repeatedly and that is how the groups were formed.

Much loneliness was revealed during the group discussions. These women feared the arrival of retirement when work which should require their daily presence would suddenly cease. A lonely existence in a single room on a marginal income was all they could anticipate. It soon became obvious that a program had to be developed which did not focus upon psychotherapy for the alteration of ego structure, but rather a program must be developed which would be orientated toward helping these patients fulfill their social needs and to meet the external problems which threatened them. To pursue this objective, the group was turned over to Mr. Louis Schuldt who was the Director of Social Work at Yankton State Hospital.

Thus, we see the development of group therapy for somatic symptoms in three different settings: The **first** growing to be conducted by a patient leader in which the patients were rewarded with approval and recognition for symptomatic improvement; the **second** conducted exclusively by the psychiatrist who tried to alter the patients' ego identification so that the masochistic type of identification would develop to an identification with the therapist's attitude toward the symptom which would eventually lead to a change in individual emotional attitudes; the **third,** the group of aging women threatened with loneliness and isolation, required therapy with emphasis upon and fulfillment of their social needs.

SUMMARY

In taking a glimpse at the development of groups in many settings, the following conclusions can be drawn: 1.) The type of patient is the first important **variable** which alters the goal one sets; that is, the presenting symptoms, the age and whether or not a personalty change is feasible. 2.) The therapist is not far behind in importance in determining how the group will develop (whether the therapist is organically oriented and satisfied with exchange of symptoms for acceptance, or whether the therapist is dynamically oriented and strives for alteration in

[2]While I was on the psychiatric staff at the Yankton State Hospital, Yankton, South Dakota.

ego identification in the patients.) 3.) The development of each group therapy program will be determined by the over-all setting in which the therapy takes place.

PRACTICAL GUIDES

Goals often have to be adjusted, adapted and modified in the end phases of treatment. Sometimes we start with reduced designs in the face of seemingly serious pathology, like a counter-transference problem. But the patient may make such unexpected and remarkable improvement that we can raise our sights and project more advanced achievement. Other times we find we have set up unrealistic and unattainable goals and are accordingly obliged in terminal phases to shave our objectives. The therapist's intent of a perfectionistic pursuit may make treatment interminable and infect the patient with similar idealistic strivings so that he is always disappointed with his progress.

One of the premordial aims of therapy is to get rid of the therapist.

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SIOUX VALLEY MEDICAL ASSOCIATION PROGRAM

Wednesday Evening February 20, 1963

7 p.m. Hospitality Room — Sheraton Martin

Your Host: Physicians and Surgeons Hospital Supply Co.; Minneapolis, Minnesota
Refreshments, Old Time Movies, Music
Wives Expected

Thursday February 21, 1963
Morning Session
Lutheran Hospital

8:30 Registration — Auditorium Nurses Home

9:00 Laboratory Application of Clinical Problems
James Brown, M.D. Pathologist, Sioux City, Iowa
William Stanage, M.D. Surgeon, Yankton, South Dakota

9:20 Control of Digitalis Intoxication
W. O. Read, Ph.D., University of South Dakota Medical School

9:40 Role of Emotional Stress in Production of Congenital Malformation
W. F. Geber, Ph.D., University of South Dakota Medical School

10:15 Coffee Break

10:30 Commonly Missed Medical Diagnoses
R. C. Larimer, M.D., Sioux City, Iowa

11:00 Urological Problems in General Practice
John Macfarlane, Sioux City, Iowa

11:20 New Drugs in OB-Gyn
Edward Hagen, M.D., Sioux City, Iowa

11:40 Warts
Herbert Leiter, M.D., Sioux City, Iowa

12:00 Luncheon: Hospital Dining Room

Afternoon Session
Sheraton Martin Hotel

1:00 Registration

1:30 Movie — Gastric Freezing, Dept. of Surgery, University of Minnesota

2:00 Office Gynecology — Today
Edwin J. DeCosta — Associate Professor of OB & Gyn. — Northwestern University, attending Physician — Passavant Memorial Hospital, Chicago, Illinois

2:30 Newer Concepts in Treatment of Shock Part I
Richard Lilliehi, Ph.D.
University of Minnesota

3:00 Visit Exhibits

3:15 Hysterectomy -- Then and Now, When and How
Edwin J. DeCosta, M.D.

3:45 Newer Concepts in Treatment of Shock Part II
Richard Lilliehi, Ph.D.

Evening Session

5:30 Social Hour — Sheraton Martin Hotel
Your Host — Cusack Harmon Drug Co.

7:00 Dinner — Ballroom
Banquet Speaker:
Project Hope in Peru
George W. Knabe, Jr., M.D.
Dept. Of Pathology
South Dakota Medical School
Dancing: Darrel Warner's Orchestra

Friday, February 22, 1963

8:30 Exhibits open

9:00 Movie — Emotional Factors in General Practice (Geigy)

9:30 Gastroenteritis — Donal Dunphy,
Head and Professor of Pediatrics
State University of Iowa

10:00 Energizers, Tranquilizers or Neither, Part I
Jackson A. Smith, Clinical Director
Illinois State Psychiatric Institute
Chicago, Illinois
Sponsored by South Dakota Mental Health Association

10:30 Visit Exhibit

10:45 Hiatus Hernia and Esophagitis
F. F. Paustian, M.D.
Assistant Professor of Medicine and Gastroenterology
University of Nebraska

11:15 Energizer, Tranquilizer or Neither, Part II
Jackson A. Smith, M.D.

12:00 Luncheon — Sheraton Martin Hotel
Discussion
F. F. Paustian, M.D.
Donal Dunphy, M.D.
Jackson A. Smith, M.D.

1:00 Movie

1:30 Ophthalmology for General Practice

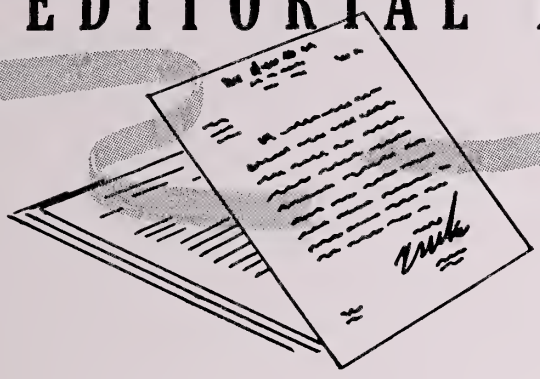
2:15 Problems of the Newborn
Donal Dunphy, M.D.

2:45 Visit Exhibits

3:00 Diverticulitis, a Potentially Grave Problem
F. F. Paustian, M.D.

3:30 Movie — Office Surgery
Samuel D. Kron, M.D.

EDITORIAL PAGE



MEDICINE'S INVESTMENT IN BLUE SHIELD

In the first six months of 1962, 75 Blue Shield Plans paid for nearly a half billion dollars worth of professional services that were rendered for those of the 50 million Blue Shield members who needed such medical services in that period. At its present rate of growth, Blue Shield will probably pay physicians more than one billion dollars in 1962.

By any measuring stick, Blue Shield is a major factor — probably a dominant factor — in the medical economy today. And it is the one operative factor which is controlled by the profession. The Blue Shield program is the only program that reflects medicine's ideas as to how a prepayment plan should be operated, what services it should cover, on what terms, and with what provisions for reimbursement of the physician's services.

While the several hundred commercial accident and health insurance companies, in aggregate, cover more people and pay out more money in the course of a year than do the 75 Blue Shield Plans, it is Blue Shield that has set the pace and established benefit patterns and fee schedules at levels that will substantially protect the patient and reasonably compensate his doctor.

What has medicine invested in Blue Shield? For the past 25 years, thousands of dedicated doctors have given lavishly of their time and energy as trustees, directors and committee members in their local Plans. Thousands more supported their efforts by providing services under arrangements which, in the early days, represented a substantial contribution to the Blue Shield program as well as to the welfare of their patients and the freedom of our medical care system.

And this investment is paying off, in benefits vastly more important than even the billion dollars worth of medical services it is underwriting this year.

Medicine's investment in Blue Shield is paying off as a solid demonstration of the ability of physicians — working together with labor, industry and community leaders — to solve the social and economic problems of modern medicine without recourse to government. It's paying off as a strong and versatile instrument by which medicine can continue to guide the economy of medicine in the days ahead.

LETTERS

To The Members of the House of Delegates:

The silver service that you gave us for a wedding gift is so lovely and so very much appreciated. It will always be a reminder to me of my bosses, my friends and some of my favorite people.

Please come and see Ron and me in Viborg. It could be a coffee stop for you next June when you are on your way to Yankton for the Annual Meeting. I will miss seeing you.

Sincerely,
Phyllis (Sundstrom) Lockwood

LETTERS TO THE EDITOR

Editor of South Dakota Medical Journal
711 North Lake Avenue
Sioux Falls, South Dakota

Dear Editor:

In reference to Dr. D. R. Studenberg's letter of October, 1962, I feel it only fair to apologize if my report caused any misunderstanding among physicians in the State.

First of all, I referred to non-National Guard physicians who were recalled because some physicians had not served their military obligation. I did not include myself in this category, since I am a National Guard physician and therefore a volunteer. Those men I referred to were recalled Reservists (also not volunteers).

Secondly, I think that the Doctor misunderstood my use of the term "Country Club" of the Army. Having never been in the Army, he would miss the irony in the fact that Ft. Riley, of all places, is **not** the Country Club of the Army.

However, I do not want any doctor to misunderstand the personal conviction that I have that each of us should serve the same as any other citizen. I agree that it would be nice if we could each decide the time when we think it necessary, although I am not naive enough to believe that this will ever be the case.

In the meantime, what I am pleading for is for us to assume our citizen obligations like citizens, and not expose our medical ranks to even more criticism than we already are receiving. "If the shoe fits, wear it."

Sincerely,
Robert H. Hayes, M.D.

N. E. MATTOX, M.D.
1881—1962

N. E. Mattox, M.D., well-known Black Hills physician, suffered a fatal heart attack while playing bridge recently.

Born December 26, 1881 at Rego, Indiana, Dr. Mattox served as a high school principal for two years before entering medical school. After receiving his degree in Medicine, he practiced at Bedford, Indiana, for four years before coming to South Dakota.

Dr. Mattox joined the medical staff of the Homestake Hospital April 21, 1917. He served there for over 32 years, retiring July 31, 1949. At that time he maintained an office in Deadwood with practice limited to eye, ear, nose and throat.

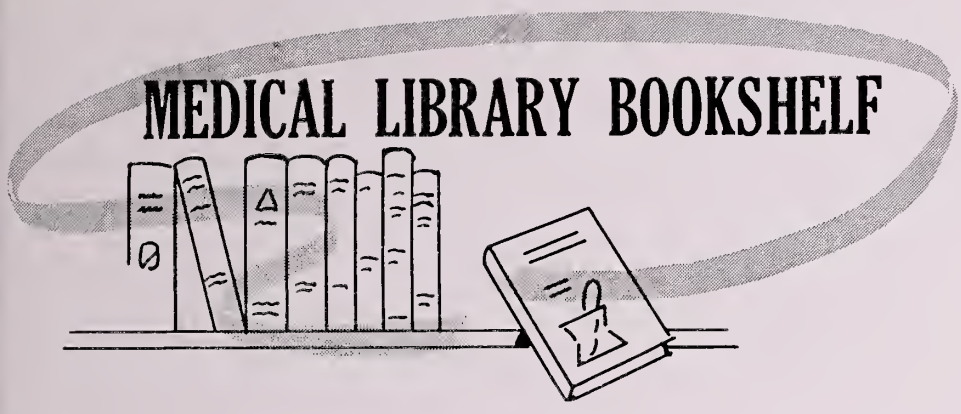
Active in civic organizations and service clubs, Dr. Mattox is credited with organizing the Lead Kiwanis Club in 1925, of which he served as president for two terms and as a member of its board of directors for several years.

He was chairman of the board of trustees of the Presbyterian Church; was instrumental in planning and building the Gold Run Inn, known then as the Highland Hotel; and was a long-time member of the Lead Commercial Club and Deadwood Rotary Club.

A member of the medical staff at St. Joseph's Hospital in Deadwood, Dr. Mattox noted his 50th anniversary in the practice of medicine this year.

Surviving in addition to his widow are six children, 12 grandchildren, and a sister.

A memorial has been established for the South Dakota Medical School Endowment Association, or any other charitable organization.



BOOK REVIEWS

This book review was contributed by John C. Foster, Business Manager of the SOUTH DAKOTA JOURNAL OF MEDICINE AND PHARMACY.

Fundamentals of Voluntary Health Care edited by George B. De Huszar.

The Caxton Printers of Caldwell, Idaho, have published a book under the title **Fundamentals of Voluntary Health Care** which seems to be the first of its kind ever compiled. Contributors to the text include authorities in the American Medical Association, the National Association for Blue Shield Plans, the deans of medical schools, British authorities on the system in England, financial experts, research experts, and many others.

The book, itself, is a source book devoted exclusively to non-governmental means of achieving satisfactory health care for the American people. The selections in the book champion the voluntary health care viewpoint.

Part I of the book is devoted to background surrounding the moral, biological, psychological, economic, and political implications. Part II of the book considers the dangers involved in government health services, a systematic analysis is made of Social Security, and the basic concept underlying government welfare activities. Emphasis is laid on the issue of voluntary versus compulsory medical care, primarily from the point of view of political economy. Part II also includes a detailed survey of voluntary health insurance, the purpose of which is to provide a perspective on its manifold accomplishments and problems.

Probably the only single source having all of the background information yet published, it is recommended for reading by physicians and others interested in the problem.

This book review written by Dr. Robert E. Van Demark, editor of the SOUTH DAKOTA JOURNAL OF MEDICINE AND PHARMACY, **Malpractice Law Dissected for Quick Grasping** (Cusumano, Medicine-Law Press, Inc., 42 Broadway, New York 4, New York, price $10.00) is a summary of the field of medical malpractice in 132 pages of language which a doctor (with no particular legal training) can understand without difficulty. It covers the entire field, not only related to physicians, but also the matter of liability of dentists, hospitals, nurses and employers in 126 pages with 6 pages of bibliography on the subject material presented. In this era of increasing malpractice suits the information presented in this book should be worthwhile to every physician.

Congenital Cardiac Disease: A Review of 357 Cases studied pathologically by Robert S. Fontana and Jesse E. Edwards, Saunders, 1962.

Dr. Fontana is a consultant in the section of medicine, Mayo Clinic and an instructor in medicine, Mayo Foundation Graduate School of the University of Minnesota. Dr. Edwards is Director of Laboratories, Charles Muller Hospital, St. Paul, Minnesota and Professor

of Pathology, Graduate School, University of Minnesota.

This book is the result of necropsy studies of 357 cases of congenital cardiac disease, and represents 256 examples of significant cardiovascular malformations observed in the section of Pathologic Anatomy at the Mayo Clinic between January 1, 1920 and July 1, 1954, together with 101 hearts from outside sources.

Two features of this publication are of interest. One concerns the treatment of the subject of longevity among persons with congenital cardiac disease. Patients are grouped according to age at death with a discussion of the types of malformations encountered at necropsy. The second discussion includes combinations of malformations and frequency of occurrence as isolated malformations and as components of combinations of malformations. Also, the types of malformations most frequently associated with a given anomaly, when this is a component of a combination of malformations.

The extensive bibliography (1182 entries) contains papers published before 1957, prior to the widespread use of open heart surgery. Although this study is made of a collection of pathologic material that is necessarily selective, it provides a source of data and statistical information concerning the frequency of occurrence, distribution according to sex, life expectancy and complications of various cardiac malformations.

Esther Howard
Medical Librarian

A 14-page pamphlet on "Football Injuries" has been prepared by Mead Johnson Laboratories and is available free to team physicians who request it. The prevention, detection, and treatment of all common injuries as well as physical conditioning and heat exhaustion are discussed.

The pamphlet, designed to assist team physicians in reducing the risk of player injury, can also be used as a practical guide for trainers and coaches who bear heavy responsibility in preliminary care of the seriously injured when the physician is absent, and who often treat minor injuries.

The pamphlet is available to physicians who write:

Professional Services Department
Mead Johnson Laboratories
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SUMMARY ANALYSIS OF PUBLIC LAW 87-792, THE SELF-EMPLOYED INDIVIDUALS TAX RETIREMENT ACT OF 1962 (H.R. 10)

1. **In General.**

Under this new law self-employed persons (professional men, small businessmen, farmers, ministers, certain commission salesmen who are not employees for pension purposes, and certain persons who perform services at home for compensation) are given a limited income tax deduction for amounts set aside to fund future retirement benefits under an employees' retirement plan that qualifies for tax exemption.

2. **Limitation on Deductible Plan Contributions for the Self-Employed.**

Annual plan contributions with respect to which self-employed persons may claim a deduction are limited to 10% of earned income or $2,500, whichever is the **lesser.** However, the allowable deduction is limited to **one-half** of the permissible contribution, or a maximum annual deduction of the lesser of 5% of earned income, or, $1,250. Plans covering multiple businesses are aggregated in applying these dollar limitations.

"Earned income" means compensation for personal services, or, in the case of a business in which both personal services and capital are material income-producing factors (a factual determination), the term means not more than 30% of the business net profits, or $2,500 whichever is the **greater,** except that if the business net profits are $2,500 or less, it means the entire amount of such net profits.

3. **Limitation on (Voluntary) Non-Deductible Plan Contributions.**

a. **Owner-employees** (i.e. sole proprietors or partners owning more than a 10% partnership interest) cannot make voluntary contributions unless they participate in a plan which also covers employees who are not owner employees. If such other employees are covered, the voluntary contributions of owner-employees are limited to the same **rate** of such contributions that is permitted other employees but in no event may they exceed 10% of earned income, or $2,500, whichever is **lesser.** Plans established under multiple businesses are aggregated in applying this limitation.

b. **Non-owner-employees** (i. e. partners owning a 10% or lesser partnership interest) may make voluntary plan contributions provided they comply with the present law requirement that such contributions cannot be discriminatory under the plan formula.

4. **Qualification of Plans Covering No Owner-Employees.**

Plans covering self-employed persons who are not owner-employees need only comply with the qualification tests prescribed under present law for employees' retirement plans, except that distributions must be made (or commence) prior to the time the employees reach insurance age 70, or retirement, whichever is later.

5. **Qualification of Plans Covering Any Owner-Employees.**

Plans covering any owner-employees must also comply with additional qualification tests, the more important of which include:

a. If a trusteed plan is used, the trustee must be a bank, except that if the plan is funded exclusively through the use of life insurance endowment, or annuity contracts, **any person** may be the trustee provided the issuing company annually supplies the Treasury Department with information concerning trust transactions with covered owner-employees.

b. The rights of employees to plan contributions must vest immediately.

c. All employees (except those customarily working less than 20 hours a week or for less than 5 months a year) who have 3 or more years service must be covered on a nondiscriminatory basis.

d. Owner-employees must consent to be covered by the plan and no benefits may be paid them prior to attaining insurance age 60 (except in case of severe disability or death) and a distribution of such benefits must commence by insurance age 70. Penalties are provided for premature distributions.

e. Excess contributions (i. e. amounts in excess of permissible limits on both deductible and voluntary contributions) cannot be made to the plan by or for owner-employees but, if made, the amount thereof (plus any net earnings thereon) must be refunded to the owner-employee within certain time limits, if penalties are to be avoided. A special exception is made to this rule for investments made by or

for owner-employees in level-premium insurance contracts where their earned incomes fluctuate.

f. Plans covering owner-employees and other employees may, under special rules, be coordinated with social security (thereby lowering the cost of the plan in certain circumstances), but only if the contributions for owner-employees do not exceed one-third of the total contributions made under the plan.

g. Multiple businesses controlled by an owner-employee or group of owner-employees are aggregated for the purpose of determining compliance with qualification tests as to coverage, contributions, and benefits, as well as for the purpose of applying contribution and deduction limitations.

6. **Permissible Investment Methods.**

a. **Bank-Trusteed Plans** — Under these plans, investment control may be retained by the employer who establishes the trust and permissible investments are limited only by the "prohibited transactions" rule which is designed to insure bona fide arm's length dealings with the trust funds.

b. **Other Trusteed Plans** — Under these plans investments may be made exclusively in life insurance, endowment, or annuity contracts provided the issuing company annually supplies information regarding transactions with owner-employees.

c. **Custodial Accounts** — A custodial account held by a bank may qualify provided investments are made solely in stock of an open-end regulated investment company, or in life insurance, endowment, or annuity contracts.

d. **Bond Purchase Plans** — Direct investments may be made in a new series of nontransferable Government Bonds under qualified bond purchase plans, the terms of which generally conform to the limitations provided in the law for owner-employee participation, except that the excess contribution rules do not apply.

e. **Non-Trusteed Annuity Plans** — Qualified plans may be funded through the purchase of nontransferable annuity contracts (and face amount certificates) directly from an issuing company.

7. **Taxation of Benefits to Self-Employed Persons.**

a. **Lump-sum distributions** are taxable as ordinary income, subject to the application of an averaging rule under which tax on the gain realized on the distribution is 5 times the **increase** in tax that results from including one-fifth of such gain in income, for which purpose income is not considered to be less than zero.

b. **Other distributions** are taxable as ordinary income except to the extent they are attributable to non-deductible contributions (which may be recovered taxfree under existing law).

8. **Effective Date.**

The law applies to taxable years beginning after December 31, 1962.

REPORT ON ACTIONS OF THE HOUSE OF DELEGATES AMERICAN MEDICAL ASSOCIATION SIXTEENTH CLINICAL MEETING NOVEMBER 25-28, 1962 LOS ANGELES, CALIF.

Health care for the aged, medical ethics, graduate medical education, expansion of the AMA Board of Trustees and a study of the sections and scientific program of the AMA were among the major subjects acted upon by the House of Delegates at the American Medical Association's Sixteenth Clinical Meeting held November 25-28 in Los Angeles.

In keynoting the Association's attitude toward Social Security health care for the aged, Dr. George M. Fister of Ogden, Utah, AMA president, told the opening session of the House:

"We will not compromise on the fundamental principles in which we believe and for which we have fought in the past with courage and good judgment. We will not jeopardize our position either by indicating a willingness to consider a compromise which would damage our basic principles, or by hasty action which might be misinterpreted."

Dr. Fister urged the entire medical profession to understand the basic issues in this struggle so that they can recognize the difference between compromise and surrender.

"The people will respond to the truth," he said, "and it is imperative that we as individuals and as an organization see that they get the truth."

The House reaffirmed, without compromise or change, the Association's present policy of opposition to the King-Anderson type of legislation and support for the Kerr-Mills program. In so doing, it also approved in principle the following suggested amendments to the Kerr-Mills Law:

1. Remove the requirement that both Old Age Assistance (OAA) and Medical Assistance for the Aged (MAA) programs be administered by the same agency;

2. Provide flexibility in the administration of the income limitations proposed under state law so that a person who experiences a major illness may qualify for benefits if the expense of that illness, in effect, reduces his money income below the maximum provided;

3. Include a provision in the law requiring state administering agencies to seek expert advice from physicians or medical societies through medical advisory committees; and

4. Provide for "free choice" of hospital and doctor under state programs.

At the same time, the House also endorsed in principle four proposed amendments to the Internal Revenue Code, designed to assist in financing the medical and hospital expenses of the aged. These amendments would: liberalize tax deductions for medical expenses of dependents over age 65; remove the 1 per cent drug limitation and include drugs as medical expenses; permit taxpayers over age 65 to receive full tax benefit for medical expenses by use of the carry-forward and carry-back principle, and provide a tax credit for medical expenses paid by the over age 65 taxpayer, proportionate to the relation between his medical expense and taxable income.

The House also approved a status report which concluded with this statement:

"It is our strong conviction that the legislative situation, the expanding health insurance and prepayment coverage, the improving economic status of the aged, and the many other factors cited in this report require that we face the 1963-1964 Congressional campaign without defeatism or complacency and with pride in the progress that has occurred. Finally, it is, above all, essential that our position not be undermined by the adoption of any policies that compromise our basic principles."

In considering seven so-called "pledge" resolutions, involving professional freedom, the House adopted a substitute resolution urging that all physicians be encouraged to support the position taken by the House of Delegates in June, 1961.

That policy statement said:

"The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

"The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest and that it will not be a willing party to implementing any system which is detrimental to the public welfare."

Medical Ethics

The Judicial Council submitted a report containing new opinions on the medical ethics involved in physician ownership of drug stores, drug repackaging houses and drug companies, dispensing of glasses by ophthalmologists, and advertising practices of medical laboratories. The House decided that the questions of physician ownership of drug stores, drug repackaging houses and drug companies, and the dispensing of glasses by ophthalmologists, should not be acted upon at this time. Those opinions were returned to the Judicial Council for further study and report. The House approved the portion of the report relating to advertising practices of medical laboratories and agreed that the propriety of such practices should be determined at the local level in compliance with the new opinion. The House also approved the rules of procedure adopted by the Judicial Council for disciplinary action in cases where the Association now has original jurisdiction as conferred by the June, 1962, change in the Bylaws.

Interns and Residents

A special report on the compensation of interns and residents, which was published in the October 27 issue of JAMA, was presented to the House by the Council on Medical Education and Hospitals and the Council on Medical Service. The report was submitted as information only, with a request for further study, comments and suggestions. The House urged that all delegates, hospital staffs and medical societies discuss the report and forward all suggestions to the two Councils in time to influence the form of the report to be presented for action at the June, 1963, meeting.

In another action on graduate medical education, the House approved a report on internships and hospital services in which the Council on Medical Education and Hospitals recommended numerous changes in the Essentials of an Approved Internship. The House declared that "their acceptance will further strengthen the educational values of the internship and advance American medicine's contribution to worthy goals of international educational exchange."

The House modified one Council recommendation to read as follows:

"In order to maintain high standards of education and better assure the patients' welfare, at least 25% of the total house staff (interns and residents) of a hospital should be graduates of accredited United States or Canadian medical schools. When United States and Canadian graduates represent a lesser portion of the house staff for two successive years, this will warrant that serious consideration be given to disapproving the internship."

The House instructed the Council on Medical Education and Hospitals to exert every possible effort and influence so that all hospitals with approved house officer training programs accept a reasonable number of foreign medical school graduates.

Board of Trustees

The House, by a vote of 130 to 48, adopted changes in the Constitution and Bylaws which would have implemented the June, 1962, recommendations of the Ad Hoc Committee on the Board of Trustees, including expansion of the Board from 11 to 15 members. However, the Judicial Council later informed the House that the affirmative votes necessary to amend the Constitution should have totalled at least 144, or two-thirds of the 216 voting delegates registered at the Wednesday session. The House then adopted a motion to vote on the proposed Constitutional amendments, in accord with the changes made in the Bylaws, at the opening session of the June, 1963, meeting.

Sections and Scientific Program

A report by the Committee to Study the Scientific Sections, recommending major changes in the organizational structure and scientific program of the Association, was presented to the House by the Board of Trustees. However, because of many requests for delay in approval, the House instructed the Speaker to appoint an Ad Hoc Committee composed of members of the House, and including representatives of the sections, to study the subject and report next June.

Miscellaneous Actions

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

Instructed the Board of Trustees to use every influence in their command to have the **Hill-Burton Law** amended in such a manner as to eliminate all categorical grants, eliminate the term "diagnostic and treatment centers" from any listings in the act and prevent federal funds being awarded under existing law as a grant to closed panel medical corporations to build diagnostic and treatment centers.

Declared that it is both the responsibility and duty of the AMA to submit testimony before Congress on the subject of **research appropriations** in the health field.

Urged state and county medical societies to continue promoting the aggressive, consistent development of **Blue Shield** senior citizen programs.

Encouraged medical societies and physicians to provide cooperation and leadership in the formulation and operation of regional **hospital planning** bodies.

Approved **Essentials** of Acceptable Schools for Inhalation Therapy Technicians, Cytotechnology and Medical Technology and of Approved Residencies in Pediatric Cardiology.

Recommended that a Board report and two resolutions dealing with the **"Liberty Amendment"** be re-referred to the Council on Legislative Activities for further study.

Warned against the dangerously low level of immunization for **smallpox** and urged physicians and their patients to maintain the needed protection.

Pointed out that state and county medical societies should collaborate with departments of **public health** in the interest of community health, always keeping in mind the need for a proper balance between local public health programs and the private practice of medicine.

Authorized the Board of Trustees to investigate the feasibility of establishing a **physicians' pension plan** and to present a plan for the implementation of such a program to the House in June.

Instructed the Board of Trustees to study the feasibility of **regional clinical sessions,** taking into consideration the already established regional meetings of medical specialty groups and the Academy of General Practice.

Commended the Council on National Security and its Committee on **Disaster Medical Care** for initiating a visitation program with committees on emergency medical service of state medical societies.

Expressed appreciation and thanks to the **Woman's Auxiliary** for their impressive accomplishments in behalf of our free society.

Opening Session

The delegates learned from a report by the American Medical Association Education and Research Foundation that one out of every ten medical students in the U. S. is now benefiting from the new student loan program. Since its inception nine months ago, the program has granted loans totaling more than nine million dollars to 3,042 medical students and 1,787 interns and residents, with applications being received at a rate of 150 per week. It also was announced that Merck Sharp & Dohme pharmaceutical company is making a second matching grant of $100,000 in support of the loan fund. The AMA-ERF also received contributions totaling $440,583 from physicians in five states for financial aid to medical schools.

Registration

Final registration at the meeting reached a total of 10,908, including 5,209 physicians.

F. J. L. Blasingame, M.D.
Executive Vice President
American Medical Association

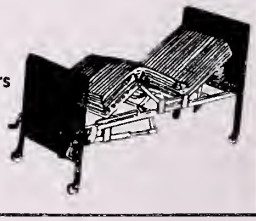
PHYSICIANS NEEDED, INTERNIST

Fourteen man Iowa group has opening for Board qualified Internist. City of 30,000, new Clinic Building, complete laboratory and X-ray. Partnership in two years — salary open. Write Box A-1, Journal of South Dakota State Medical Association.

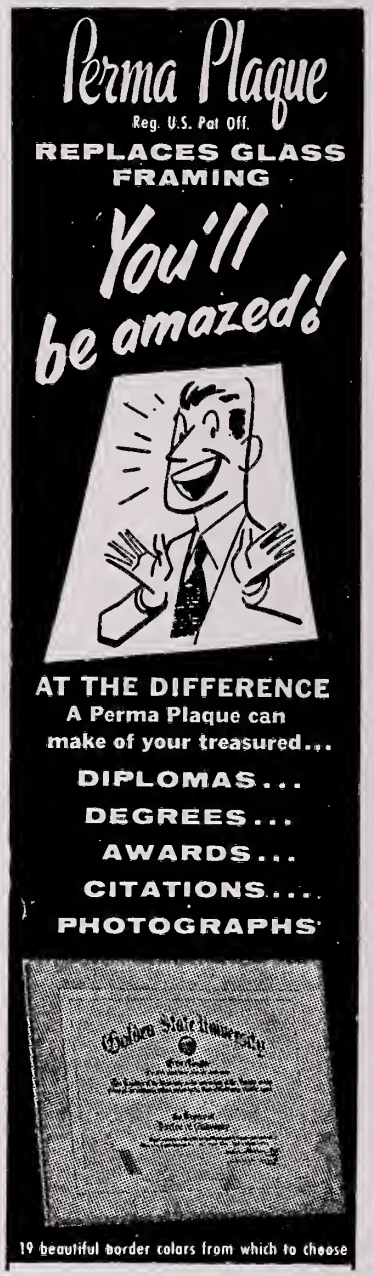


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NEWS • NOTES • • • BIRTHS • • • CHANGES • NEWS

Pop's Proverbs

Is your nose long enough to reach beyond your own business?

NEWS NOTES

Elayne Saba, Bismarck, North Dakota, became the bride of **Dr. R. G. Nemer** of Gregory on November 24th. Dr. Nemer started his practice in Gregory last summer.

Looking for physicians, with active medical committees, are Geddes, Lake Andes, Waubay and Woonsocket. Doctors seeking locations in South Dakota should write the Placement Service, South Dakota State Medical Association in Sioux Falls.

Dr. E. B. Jackson, Waubay, passed away November 26th. Dr. Jackson was a pioneer South Dakota physician who had been retired for many years.

THIRD DISTRICT HEARS ANDERSON

At a dinner meeting at the Flandreau Indian School Tearoom on Thursday, December 6th, the Third District heard a presentation on "Mediastinal Cysts" given by **T. R. Anderson, M.D.,** Sioux Falls. Election of officers for 1963 was also held.

TAYLOR PASSES BOARD

William Taylor, M.D., associated with the Aberdeen Medical Center, Aberdeen, South Dakota, has passed the final tests of the American Board of Internal Medicine.

N. C. CONFERENCE HELD IN MINNEAPOLIS

The annual North Central Medical Conference was held in Minneapolis on November 10th and 11th.

The program, aimed at some of the socio-economic facets of medicine, covered TB control programs, osteopathy, chiropractic, Kerr-Mills implementation, internship and residency problems, professional pension plans, AMPAC, Saskatchewan, and a report from the A.M.A.

Only six South Dakota physicians were present at the meeting, which is the smallest delegation from this state in twenty years. Those attending were Doctors **Howard Wold,** Madison; **A. P. Peeke,** Volga; **R. A. Buchanan,** Huron; **C. M. Kershner,** Brookings; **D. A. Gregory,** Milbank; and **M. M. Morrissey,** Pierre. Three staff members—Mrs. Butler, Mr. Erickson and Mr. Foster — were in attendance, as was Mrs. Howard Wold, representing the Auxiliary.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next scheduled examination (Part II), oral and clinical, will be conducted for all candidates at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board, April 29-May 4, 1963. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who have participated in the Part I examination will be notified of

their eligibility for the Part II examination as soon as possible.

Current Bulletins of the American Board of Obstetrics and Gynecology outlining the requirements for application, may be obtained by writing to the Secretary. All prospective candidates are urged to review the current requirements before applying for Board examination.

Diplomates are requested to keep the Board office informed of any changes in address.

Office of the Secretary:
Robert L. Faulkner, M.D.
2105 Adelbert Road
Cleveland 6, Ohio

BUCHANAN NAMED N. C. PREXY-ELECT

R. A. Buchanan, M.D., Huron, was elected president-elect of the North Central Medical Conference during its meeting November 11th. Dr. Otto Glesne of Fort Dodge, Iowa, was named president. Dr. Buchanan will succeed Dr. Glesne at the close of the 1963 session.

Dr. Buchanan has been president of the South Dakota State Medical Association, is currently president of the South Dakota Board of Medical Examiners, and has received the South Dakota State Medical Association's Community Service Award.

COMING MEETINGS

Interested members of eight professions will attend the Fourth Annual Congress of the Professions in Lansing, Michigan, on February 8-9, 1963.

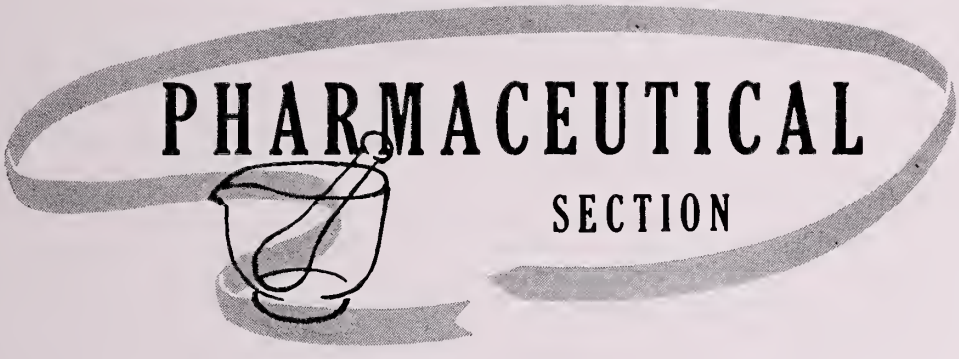
Professions in attendance at the Congress will be Architecture, Education, Engineering, Dentistry, Medicine, Law, Pharmacy, and Veterinary Medicine.

Addressing the First General Assembly on the opening day of this Congress will be the Presidents or Presidents-elect of each of the national professional associations representing these professions.

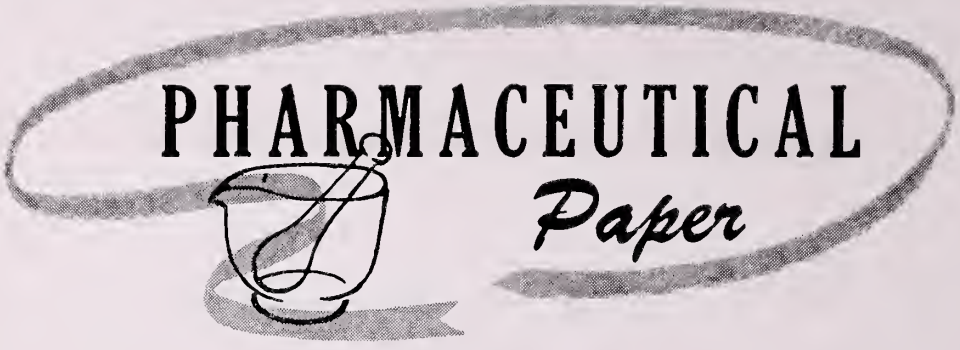
Subjects under discussion at the Congress range widely in the areas of Legislation, Education, Public Relations, Professional Relations, and Professional-Business Services.

Eligible to attend are all members in good standing of the national, state, and local professional associations representing the professions noted above.

Location of the Congress meeting is the Jack Tar Hotel, Lansing, Michigan. Further information may be obtained by writing to the Congress of the Professions, 120 West Saginaw Street, East Lansing, Michigan.



GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota



FACTS ON THE OPERATION OF PRESCRIPTION PHARMACIES*

The Tenth Annual Survey of Operating Costs of Prescription Pharmacies is sponsored by the American College of Apothecaries as a service to its Fellows and to the entire pharmaceutical profession. The study provides reliable indications of the costs of rendering services by those pharmacies whose prescription volume accounts for over 60 percent of the total volume and provides an insight into the unique characteristics of this type of pharmacy compared to the general type pharmacy .

It seems imperative that the pharmacist be constantly aware of the costs involved in making good pharmaceutical service available so that he may be in a position to control those factors which are controllable and adjust his fees so as to provide the public with the best possible pharmaceutical service at fair and equitable costs. One of the purposes of this study is to provide all pharmacists with a better insight into the true costs of making pharmaceutical service available and to stimulate a critical evaluation of their operation so as to improve their managerial ability.

The 1961 Study

The facts in this year's study are taken from reports of 184 pharmacies, an increase of 20 or about 12 percent over the previous year. Again, this year an important and significant feature of the study is the availability of a separate tabulation of 144 pharmacies which have reported both in 1960 and 1961. It is actually within this identical group that we can derive a true evaluation of the changes that have taken place over the past year. This year's study includes reports from pharmacies in 38 states, providing a fairly wide geographical distribution.

As in previous years, a uniquely different area of operation is explored. Last year's study delved into information concerning fringe benefits; this year, with the increasing interest in the professional fee method, a portion of the report is devoted to information in this area.

The 1961 Pharmacies

This year's survey of prescription pharmacies is based on a total of 184 pharmacies in a wide geographic area of the United States and includes a small sampling of pharmacies operated by Canadian Fellows of the College. The "average" pharmacy represented in this year's survey had sales of 168,-717. As shown in Table IV, 67.5 percent of these sales were represented by the prescription area. This is, of course, a much larger percentage than would be shown by the national average of all pharmacies and is responsible for the unique characteristics and differences in operating costs which these pharmacies possess.

Not included in this figure of 67.5 percent is, approximately, an additional 15 percent of sales which go to the medical and allied professional groups, as well as a sizeable per-

* Prepared by The American College of Apothecaries.

centage of items in the health field such as surgical supports, hearing aids in some cases, and so-called prescription accessories. However, it is interesting to note that the pharmacists reporting do not all conduct pharmacies which exclusively offer prescription services. In many communities and in many pharmacies the Fellows of the College do have available health needs and toiletries but all indicators point to the fact that it is the prescription area over the years that has contributed to the growth and strength of these operations.

A number of the pharmacists reporting in this survey have and operate multiple units and the 184 pharmacies actually represent 130 separate organizations with the average sales per organization being $238,917 and the total number of prescriptions on the same basis being 46,329. These figures, if they can be projected on the basis of A.C.A. total Fellowship, indicate most clearly that the Fellows of the American College of Apothecaries account for a relatively large percentage of total prescription volume in the country in relationship to the number of pharmacies represented in the College.

A Direct Comparison

In the analysis of this year's survey much of the emphasis will be placed on those pharmacies which have reported both in 1960 and 1961. Every effort is made to encourage this, since it is felt that with these sets of figures more reliable conclusions can be drawn which more clearly indicate trends. Of the 164 pharmacy reports analyzed last year, 144 reports were received this year which provides an excellent indication of the continuity of the reports indicated in the survey and, hopefully, an indication of the value of the individual analyses which are rendered those submitting their figures.

The comparative operating information on these pharmacies appears in Tables I and II. These 144 pharmacies showed a very slight

Table I

Comparison of Operating Costs
Of Identical Pharmacies 1961 vs. 1960

	1961	1960	% Change
Average Sales	$180,712	$179,746	+ .5
Prescription Charges	66.6	61.1	+9.0
Cost of Goods Sold	56.4	56.5	- .2
Gross Margin	43.6	43.5	+ .2
Total Expenses	40.1	39.4	+1.7
Net Profit	3.5	4.1	-14.6
Total Net plus Owners' Salary	10.7	11.3	- 5.3
Average Inventory	$ 29,396	$ 28,709	+2.4
Average Prescription Fee	$ 3.50	$ 3.32	+5.3
New Prescriptions	16,197	15,881	+2.0
Refill Prescriptions	18,265	17,414	+4.9
Total Prescriptions	34,462	33,295	+3.5

Table II

Details of Expenses	1961	1960	% Change 1960-61
Owners' Salary	7.2	7.2	——
Employees Wages	20.7	20.4	+1.4
Rent, Heat and Light	3.9	3.7	+5.4
Advertising	1.6	1.7	-5.8
Delivery	1.0	1.0	——
Depreciation	.9	1.0	-10.0
Taxes and Licenses	1.0	.9	+11.1
Insurance	.7	.6	+16.6
Telephone	.7	.7	——
Repairs	.2	.2	——
Miscellaneous Expense	2.2	2.0	+10.0
Total Expenses	40.1	39.4	+ 1.7

increase in total reported sales of .5 percent. This, of course, is not a significant increase and indicative of the result of many pressures which were brought to play on the independent practicing pharmacist during the year 1961. Yet it is significant in the fact that it does point out the relative strength of these operations against these varied kinds of pressures which have been and are developing.

The 144 pharmacies are actually part of 96 different operations with a number of the pharmacists operating multiple units. The average volume per operation was $276,588, as contrasted to last year of $273,280, or an increase of 1.2 percent per operation. This trend toward multiple pharmacies has increased and appears to be a result of the shifting lay and physician population. There is a tendency to establish smaller pharmacies in newer areas and neighborhoods, particularly where a down-town pharmacy has a well established reputation. The advantages and even necessity of such a type of expansion appears obvious.

Prescription Information

As indicated in Table I, those pharmacies reporting in both years showed an increase of 3.5 percent in the total prescriptions filled and, as has been characteristic for several years, the rate of increase for refills exceeded that of new prescriptions. The ratio of new prescriptions to total was 47 percent as compared to 47.7 percent the previous year. The total prescriptions per operation as contrasted to the per pharmacy number was 54,042.

It is also interesting to note that the average fee showed an increase of 5.3 percent, going from $3.32 to $3.50. Thus the combination of an increasing number of prescriptions plus an increasing fee raised the total percentage of prescription charges to total sales to 66.6 percent or an increase of 9 percent. The fact that total sales remained relatively constant is indicative of the fact that there is a continual decrease in the sale of many of the traditional pharmacy items sold over the counter due to new forms of competition. Yet it appears from the refill ratios and other information on the prescription area that the prescription services, at least in these pharmacies, have not been seriously affected.

There are certain limitations which must be raised in attempting to draw some conclusions from these data. The increase in prescription fees could result more from the nature and quantities of the prescriptions rather than from an increase necessitated by increasing costs. This seems to be the situation when we reflect on the decrease in net profit shown. Thus one of the real problems in showing trends for costs of medical care is obvious. In comparing prescription fees from year to year, we are not comparing the identically same items. The nature of the prescriptions, what they will accomplish, their long term or short term relationship, are all factors which make true comparisons not entirely possible.

Cost of Goods Sold

The Cost of Goods Sold for 1961 averaged 56.4 percent, a very slight decrease of .2 percent over the previous years. This is substantially below that ascribed to the average pharmacy. Considering the costs of providing the professional services which should and must be offered by the prescription pharmacy or any pharmacy offering good professional service, this lowered Cost of Goods Sold is essential if the prescription pharmacy is to continue to operate on a profitable basis.

Most of the pharmacies reporting, purchase in sufficient quantities to permit direct purchases and thus can benefit from maximum discounts. Certain policy changes during 1960 have mildly encouraged this practice and this could be an explanation for the improvement in this area. In addition, almost all of those reporting indicate that they regularly take all cash discounts. Proper purchasing control along with a realistic fee schedule are essential if the pharmacy is to continue to provide the services it renders to the public, the allied health groups and the manufacturer. Circumstances have demanded that closer attention be paid to the buying function as performed in the pharmacy if costs are to be kept under control.

Gross Margin

As a corollary the slight decrease in Cost of Goods Sold produced a corresponding increase in Gross Margin, which also rose about .2 percent to 43.6 percent of sales. This larger Gross Margin, as compared to so-called "pharmacy averages," must be directly attributed to the unique characteristic of the prescription pharmacy operation since a large proportion of the charges made are for professional services and not as simply a mark-up

on merchandise sold. This margin is essential in light of the fact that operating expenses are much higher and in 1961 represented 40.1 percent of sales, an increase of 1.7 percent, which was much greater than the slight increase in Gross Margin.

The need for more closely evaluating the factors that contribute to Gross Margin and adjusting charges accordingly, is obvious by this year's report; yet the average pharmacist's cost accounting records, the analysis of them and the necessity of acting on the basis of result, all leave something to be desired. It is essential to continually analyze the operation and make adjustments when necessary. The costs of providing professional services are much higher and thus an increase in Gross Margin is to be expected. However, it is also important to point out that in those pharmacies devoting a majority of their efforts toward the providing of professional services, they are utilizing the professional help much more efficiently and economically and that if true cost accounting were employed it would be shown that those pharmacies filling relatively few prescriptions have extremely higher costs of filling each prescription than does the pharmacy with a large professional complement but which is using the pharmacist for his primary purpose.

Even the Gross Margin herein represented does not truly represent the figure to cover prescription department operating cost for still over 30 percent of sales are probably being transacted on a low marginal basis. It is equally essential to recognize that prescriptions are not ordinary items of commerce and represent both a commodity and a professional service. Thus it is both impractical and unfair to apply standard marginal concepts of typical drugstore merchandise to the prescription department. There is no sound professional or financial basis for such a procedure and to do so is but inviting difficulty and possibly disaster.

Total Expense

Total Operating Expenses for 1961 in those pharmacies reporting in both years was 40.1 percent or an increase of 1.7 percent over the previous year. One of the factors contributing to this increase was a 1.4 percent increase in employees' salaries. It is interesting to point out how important the human element is in the operation of the prescription pharmacy, a fact which contributes to its relative strength. Employees' wages, both professional and non-professional, account for over 50 percent of the total expenses. If the owner's salary is included in this figure, the total rises to nearly 70 percent of all expenses. This very fact makes it absolutely essential that every effort should be made to see to it that the proper type of personnel are employed, that they are trained adequately and that they are continually appraised as to their performance and effectiveness. The prescription pharmacy is dependent on people and personal service and true management demands the proper attention to this most valuable asset.

In analyzing the other expense factors there appears to be a slight increase in those factors which are more or less uncontrollable and typical of the gradual increase in costs of operation. The rent, heat, and light factor showed an increase of 5.4 percent, taxes and licenses 11.1 percent and insurance 16.6 percent as well as miscellaneous of 10 percent, all difficult to control and many times over which the owner has little or no control. Advertising expenses, a somewhat controllable expenditure, showed a decrease. This is frequently the first area where decreases are made in a tightened profitability picture but it must be questioned as to whether such decreases are wise at such times and whether even more expenditures, sensibly evaluated of course, might not be more in order during such periods.

Total Return

In the light of increased expenses and only an insignificant increase in Gross Margin, the net profit showed a marked decrease of 14.6 percent, falling to a level of but 3.7 percent of sales. When this is added to the owners' withdrawal, we note a decline to 10.7 percent as compared to 11.3 percent in 1960. This reduction in total return has become almost an annual trend and one which cannot continue much longer. It is important to note that this figure is before taxes and certainly does not represent an adequate return for the efforts and investment. Again the need for greater effective knowledge and control of the operation is spotlighted and the desirability for a constant analysis and readjustment of the basis for establishing fees for professional services is obvious. The

increase in employee salaries points out that in order to attract good pharmacists and be in a position to offer a high type of professional service, which the public has every right to expect, adequate professional compensation must be provided. The pharmacy owner cannot continue to subsidize increasing operating expenses from his total return indefinitely. A total reappraisal seems to be in order.

Inventory

The average inventory of the pharmacies reporting in both years increased slightly from $28,709 to $29,396 or an increase of 2.4 percent. This increase does exceed the increase in sales and is not a desirable trend, yet in the face of a number of companies encouraging direct purchasing, it does not represent an alarming increase, in fact does indicate a good level of control. The inventory represented 16.5 percent of sales and below that of the average community pharmacy.

In further exploring the inventory picture certain facts are of apparent interest. For the purpose of this survey, average inventory is determined by adding the opening and closing inventories and dividing this by two. In analyzing the opening and closing inventories, a difference was discovered which must be pointed out. It was found that the average opening inventory was $29,438 while the average closing inventory was $29,842 or an increase of less than 2 percent.

This increase, however, was not uniform and even more so than last year there appears to be better efforts toward controlling the inventory problem. Interest and cooperation toward solving the problem have been evidenced by many manufacturers in adopting realistic return goods policies. However, there are still too many who are asking pharmacists to take losses due to conditions over which they have no control. There is a need for still a closer meeting of minds in this direction.

To substantiate the premise that inventory can be controlled by individual effort a close analysis of each report revealed that in the relationship of opening and closing inventories:

16.2 percent of the pharmacies showed little or no difference

38.7 percent of the pharmacies showed a decrease in closing inventory, while in

46.1 percent of the pharmacies, closing inventories increased.

The Total Survey

The following tables and analyses are based on the total of the prescription pharmacies and no effort will be attempted to show any comparative trends by the over-all figures other than in the following Table III, which shows the composite growth of the survey and percentages as they have developed over the years. The figures taken on a single year's basis can serve as a guide against which an individual pharmacist can evaluate his operation and thus be in a better position to determine how his operation compares to that of his associates.

Table III

How Does It Compare?

	1961 (184)	1960 (164)	1959 (181)	1958 (154)	1957 (107)	1956 (95)	1955 (59)	1954 (48)	1953 (38)	% Change 1960-61
Net Sales	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	——
Cost of Goods Sold	56.4	55.9	56.9	57.9	56.9	54.2	53.9	52.8	53.2	+ .9
Gross Margin	43.6	44.1	43.1	42.1	43.1	45.8	46.1	47.1	46.8	- 1.1
Operating Expenses	39.9	39.9	38.6	37.6	39.1	40.7	41.1	40.3	40.4	——
Net before Taxes	3.7	4.2	4.5	4.5	4.0	5.1	5.0	6.8	6.4	-11.9
Net Plus Owners'	10.9	11.3	11.8	11.8	12.0	13.2	13.4	14.1	13.9	- 3.5

Delivery Service

In analyzing Tables IV and V, it appears to be desirable to study some of the factors in somewhat more depth. One important service rendered by these pharmacies is Delivery Service. This has become a vital and necessary service offered by the pharmacist and can well serve as a stimulus to offset lack of parking and shifting population trends. It is frequently difficult to really ascertain the true cost of offering this service unless it is all handled on an outside contractual basis. Well over 90 percent of those reporting in the survey indicated they offer a delivery service, yet less than 60 percent were able to provide figures which appeared to indicate the cost of these services.

Of those pharmacies surveyed, delivery service, exclusive of salaries amounted to 1.0 percent of sales. The details on delivery service which those pharmacies that kept adequate records were able to supply are tabulated in Table VI.

Pharmacist Employees

As previously indicated, salaries account for well over 65 percent of the total operating expenses. Again this year efforts were made to compile data concerning pharmacists' salaries and hours of employment. This information is summarized in Table VII and as can be seen there is a decrease in the average work week for the pharmacist as reported in this study.

Table IV

Operating Cost of Prescription Pharmacies

	1961	1960	1959
Number of Pharmacies	184	164	181
Average Sales	$168,717	$191,298	$176,452
	%	%	%
Prescription Sales	67.5	69.5	62.0
Cost of Goods Sold	56.4	55.9	56.9
Gross Margin	43.6	44.1	43.1
Total Expenses	39.9	39.9	38.6
Net Profit	3.7	4.2	4.5
Net Profit plus Owners' Salary	10.9	11.3	11.8
Average Inventory	$ 28,753	$ 31,680	$ 28,948
Inventory %	17.0	16.6	16.4
Average Number of Prescriptions	32,323	41,441	36,104
Average Prescription Fee	$ 3.49	$ 3.42	$ 3.28

Table V

Total Expense Details of Prescription Pharmacies

	1961	1960	1959
	%	%	%
Owners' Salary	7.2	7.1	7.3
Employees Wages	20.5	19.8	19.5
Rent, Heat and Light	3.9	3.9	3.6
Advertising	1.6	1.7	1.6
Delivery	1.0	1.1	1.1
Depreciation	.9	1.1	1.1
Taxes and Licenses	1.0	1.0	.9
Insurance	.7	.6	.6
Telephone	.7	.8	.6
Repairs	.2	.3	.3
Miscellaneous	2.2	2.5	2.0
Total Expenses	39.9	39.9	38.6

Table VI

Delivery Service

	1961	1960	1959	1958	1957
Average Deliveries/pharmacy	44	54	52	63	60
Average Cost per Delivery	47c	47c	44c	46c	43c

Table VII

Pharmacist Employees

	1961	1960	1959	1958
Average Work Week	43.0 hours	44.5 hours	43.7 hours	44.88 hours
Average Weekly Salary	$151.20	$145.60	$143.46	$134.20
Highest Weekly Salary	$260.00	$235.00	$220.00	$220.00
Lowest Weekly Salary	$100.00	$100.00	$ 90.00	$ 85.00

The Cost of Dispensing a Prescription

The increasing interest in the fee method of charging for professional services prompted a detailed analysis into the cost of dispensing a prescription. Once this factor is known, then the pharmacist can establish the rate of return which he feels is consistent with his needs. By this method he alone is responsible for the establishment of his fee for professional services.

For each of the individuals submitting a report the cost of dispensing a prescription was ascertained, utilizing the formula which has been recommended, namely:

$$\frac{\text{Owner's Withdrawal} + (\%\ \text{Prescription Vol. X All Other Expenses})}{\text{Total Number of Prescriptions Dispensed}}$$

Naturally there was a variation in costs due to the fact that operating costs in different areas of the country vary considerably. As can be seen in Table VIII, the median cost (50 percent above and 50 percent below) falls in the $1.50 to $1.59 level. In determining an arithmetic average, by adding all of the individual fees and dividing by the total, the average cost of dispensing a prescription was $1.54. In utilizing the formula based on the figures for the "average" operation reported in the survey, the cost was calculated at $1.53. In examining Table VIII, it can be seen that in over 60 percent of the operations the costs range between $1.20 and $1.79. It is important to recognize that these figures are costs to which an equitable profit per prescription should be added to arrive at the professional fee. As a matter of information it seems desirable for all pharmacists to arrive at a cost figure for dispensing prescriptions so that they may have a better basis for establishing their charges for professional services.

Table VIII

Costs of Dispensing Prescriptions

Cost	%	Cumulative %	Cost	%	Cumulative %
Below $1.00	5.2	5.2	$1.70—$1.79	6.9	74.2
$1.00—$1.09	1.7	6.9	$1.80—$1.89	6.9	81.1
$1.10—$1.19	6.9	13.8	$1.90—$1.99	3.4	84.5
$1.20—$1.29	8.6	22.4	$2.00—$2.09	6.9	91.4
$1.30—$1.39	12.1	34.5	$2.10—$2.19	0.0	91.4
$1.40—$1.49	12.1	46.6	$2.20—$2.29	3.4	94.8
$1.50—$1.59	5.2	51.8	$2.30—$2.39	1.7	96.5
$1.60—$1.69	15.5	67.3	$2.40 & Above	3.4	99.9



MEDICAL APPLICATIONS OF RADIOISOTOPES

By
Frank A. Pettinato, Ph.D.*

The applications of radiation as a tool in diagnosis, therapy, and experimental biology have been recognized almost from the moment of discovery of X-rays in 1895 by the German physicist Wilhelm Roentgen and the discovery in 1896 of natural radioactivity in pitchblend by Antoine Becquerel. Roentgen and Becquerel, as well as Pierre and Madam Curie, who isolated radium in 1898, and many others who were working with X-rays and radium soon discovered that radiation has an effect on living tissues. The effects of X-rays and radium rays on microorganisms, seed germination and growth and their deleterious effects on protozoa, ova, and embryos were observed and studied. Intensive study of irradiated epithelial cells in an active state of division led to the discovery that immature cells and cells in an active state of division are more sensitive to irradiation than mature and resting cells, which is the basis for treating many types of skin cancers and other tumors with X-rays. From 1895 until 1942 research in radiation biology and radiology proceeded quietly and productively despite the fact that the only sources of radioactivity were the naturally occuring isotopes. With the first self-sustained nuclear reaction in 1942 undreamed quantities of radiation became available and it was possible for the first time to produce just about any type of radioisotope. The atomic age of radiation biology and medicine had arrived.

What is a radioisotope? The fundamental building blocks of an atomic nucleus are the protons and neutrons. Atoms of the same element are not necessarily alike — they can differ in the number of neutrons in the nucleus. Atoms of the same element with the same number of protons but with different numbers of nuclear neutrons are called isotopes. Many of these isotopes of an element are stable, others are not; the unstable isotopes are known as radioisotopes because, in the course of attaining a stable state, these isotopes undergo a process known as radioactive decay during which energy, in the form of radiation, is emitted. The radiation is given off usually as alpha or beta particles or as gamma rays. The energies of these radiations and their ability to penetrate matter varies tremendously. Alpha particles are capable of penetrating only 0.1 mm. or so of tissue, beta particles may penetrate up to 1 cm. of tissue and gamma rays may pass completely through a human body just as X-rays do. Only beta and gamma radiations have medical applications of any importance.

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Each radioisotope also has a characteristic half-life. This is the time during which half of the original atoms decay to other isotopes or atoms. This half-life may vary from a millionth of a second to several million years.

The unit for measuring the quantity of radioactivity is called the curie. A curie is that quantity of radioactive material in which 37 billion (3.7×10^{10}) atoms disintegrate per second. The amounts of radioactive materials used in medicine are the millicurie and the microcurie, representing one-thousandth and one-millionth of a curie respectively. Millicurie quantities are usually used therapeutically; microcurie quantities are used in diagnosis and tracer studies.

Radioisotopes used in medicine are produced at Oak Ridge National Laboratories by bombarding a stable element in the reactor with neutrons or other subatomic particles. The resulting material, containing unstable atoms which emit radiations, is then processed and purified for pharmaceutical or medicinal use. Radioisotopes for internal use are those which are rapidly and completely excreted and which have a short half-life. Since isotopes for diagnostic purposes are given in relatively small doses, they present little hazard to the patient or to the medical personnel working with them; those radioisotopes used in therapy are given in larger amounts and do involve some hazard to the patient and those near the patient but decay so rapidly that the potential hazard is of relatively short duration.

It is the unique ability of radioisotopes to emit radiation which can be detected with almost incredible sensitivity that makes them so useful in diagnostic procedures, tracer studies, and medical research. In fact, it has been stated that the use of isotopes in medical and biological research is making contributions to knowledge equal to that made by one of our greatest research tools, the microscope itself. The uses of radioisotopes in tracer diagnosis are unlimited. They continuously emit detectable radiation as they decay so that the distribution, site of action, metabolism and excretion of radioactive substances can be traced with almost unbelievable accuracy. Tracer methods are now used to diagnose the activity of nearly every organ in the body. Most of these tracer diagnostic techniques are rapid, simple, harmless to the patient, and much more reliable than any of the classical methods.

Although many radioisotopes are employed in diagnosis and therapy, only some of the more widely used and established isotopes and procedures will be considered here.

Radioactive Iodine

Radioactive iodine is probably the most widely used isotope in both diagnosis and therapy. When given orally or intravenously as sodium radio-iodide (sodium iodide in which the iodine is radioactive), it is rapidly absorbed. About one-half is excreted and the remainder is taken up by the thyroid gland within 24 hours. Thyroid disease is diagnosed by measuring, with a suitable radiation detector, the amount of iodine taken up by the thyroid gland, the amount excreted in the urine or the amount in a blood sample. The rate of thyroid uptake by the gland is a useful indicator of a normal or diseased thyroid.

The isotope is also used to seek areas in the body to which residual cancerous tissue may have spread following surgical removal of a cancerous thyroid. By giving an appropriate dose and then scanning the entire body with radiation detectors, the cancerous tissue which has taken up radioactive iodine can be readily located.

Radio-iodine is also used in the treatment of hyperthyroidism, toxic nodular goiter and in some cardiac conditions. In treating hyperthyroidism and toxic goiter, a sufficient dose of the isotope is given to reduce thyroid hormone production by destroying part of the thyroid gland. In certain cardiac conditions a part of the thyroid gland may be destroyed, even if it is normal, in order to reduce the metabolic rate and lessen the work load of the heart.

The treatment of thyroid cancers, using this isotope, has been largely unsuccessful because these tumors often fail to take up the iodine and thus are not exposed to radiation.

Radioactive iodine is also used extensively in combination with certain organic substances. For example, normal serum albumin when "labeled" or "tagged" by the addition of radioactive iodine, is one of the most useful of all medicinal isotopes. The radio-iodinated serum albumin, when injected intravenously, mixes rapidly with the circulating blood. By withdrawing a blood sample, the total blood

and plasma volume can be accurately calculated from the amount of radioactive dilution of the sample. Information on blood and plasma volume is extremely important to the physician or surgeon when he wants to determine how much blood to give following surgery or determine blood loss during hemmorhage, plasma loss in severe burns and in other pathological conditions in which blood and plasma volume are reduced. Cardiac output or the "pumping" ability of the heart as well as circulation time can be accurately measured by using radioactive serum albumin. This isotope also has application in localizing brain tumors. Following its injection, the tumor area shows greater radioactivity than the non-tumor area of the brain.

Another use for radioactive iodine is to determine fat absorption by the administration of a radio-iodinated neutral fat and fatty acid such as, triolein and oleic acid. Before a fat can be absorbed, it must be broken down by pancreatic enzymes into fatty acids and glycerin. How well the process of splitting the fats and how the fatty acids are then absorbed is readily and accurately determined by giving a labeled fat and/or fatty acid and measuring the amount of radioactivity in the feces or in a blood sample. In this manner, faulty fat absorption due to such conditions as sprue, ileitis, colitis, or pancreatic disease can be simply and rapidly diagnosed.

Radioiodine-labeled dyes and urographic agents are making it possible to measure liver and kidney function directly and accurately.

Radioactive Cobalt

Radioactive cobalt is used to label Vitamin B_{12} as a diagnostic test for pernicious anemia. Those patients who have pernicious anemia lack the intrinsic factor necessary for the absorption of B_{12}. The amount of radioactivity in the urine indicates the degree of absorption of the vitamin.

Radioactive cobalt-60 is also used to supplement or replace radium in cancer therapy by external plaque administration, by placing it in a body cavity or by implanting it in the tissue to be irradiated. The radioactive cobalt is less expensive and less difficult to produce than radium.

Radioactive Gold

A colloidal suspension of radioactive gold is used in the treatment of ascites (accumulation of fluid in the body cavities) due to cancer. The gold acts on the tissue surfaces in some way to reduce fluid accumulation. Still in the experimental stage is the technique of injecting radioactive gold directly into certain tumors and as a prophylactic after surgery for malignancy in an effort to destroy any malignant cells that might remain.

Radioactive Chromium

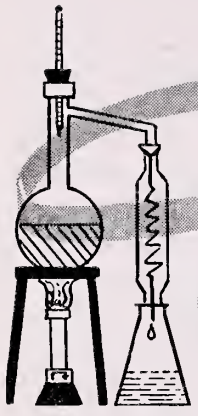
Radioactive chromium, as sodium radiochromate, is used to selectively label the red cells of the blood and hence serves as a useful tool to measure circulating red cell volume, red cell survival time or whole blood volume.

Radioactive Phosphorous

As sodium radiophosphate, radioactive phosphorous has been used successfully in the treatment of polycythemia vera, a disease characterized by persistent increase in red blood cells due to excessive erythroblast formation in the bone marrow. Therapeutic doses depress bone marrow function and thus keep the disease under control.

Summary

In conclusion, it should be mentioned that the applications of radioisotopes in biological and chemical research, as well as applied industrial uses, are growing tremendously. Pharmacists in industry are using radioisotopes as research tools in drug assays, drug absorption, excretion, and metabolism studies and in investigations of plant biogenesis and biochemistry. In recognition of the applications and potential applications of radioisotopes in the pharmaceutical sciences, many schools of pharmacy now offer courses in radioisotope technology and others expect to establish such courses in the future. Although the average community pharmacist may never be called upon to dispense radioactive medicinals, hospital pharmacists are often called upon to order, store and prepare solutions of radioisotopes.



Advances In Drug Research

NEW LONG-LASTING ANTIMALARIAL UNDERGOING TRIAL

Clinical trials of a long-lasting antimalarial which thus far have been protective nearly ten times longer than conventional suppressives are being conducted under the supervision of Public Health Service scientist, Dr. G. Robert Coatney. He reported recently to the American Society of Tropical Medicine and Hygiene meeting at Atlanta, Georgia, on the initial success with the new drug designated CI-501.

The product was developed by scientists at Parke, Davis & Company, Ann Arbor, Michigan. It is not yet available for general use. Parke-Davis supplied the drug employed by Dr. Coatney and his associates, Dr. Peter G. Contacos, Harvey A. Elder and Mr. John W. Kilpatrick. Parke-Davis and also Christ Hospital Institute of Medical Research investigators reported at the meeting on laboratory and animal work with the new antimalarial.

If the promise of initial trials in volunteers is borne out under actual field conditions, CI-501 should greatly increase the chances of success in world-wide malaria eradication efforts. The U. S. plays a major role in the program to eliminate this disease, which afflicts 200 million and kills 2 million each year.

Dr. Coatney, Chief of the Laboratory of Parasite Chemotherapy, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Maryland, and his associates conducted the trials at the United States Penitentiary, Atlanta, Georgia. Some 50 inmate volunteers participated in the study.

The first injections of the new antimalarial were given November 24, 1961, to five volunteers. The drug was injected intramuscularly at a dosage of 5 mg/kg of body weight. Within two months, 25 additional volunteers received the drug. Most were bitten by heavily infected Anopheles quadrimaculatus mosquitoes about a week after the suppressive injections, but a few were not challenged until as late as 5½ months after being given the protective drug.

Of ten volunteers in the first two groups, for example, 2 were bitten once, 8 twice, 6 three times, 4 four times and 2 eight times, at approximately monthly intervals. Each had received only one injection of CI-501. Yet, none of these people developed any evidence clinically or parasitologically of malaria. Meanwhile, other volunteers serving as controls and not given the drug invariably came down with malaria when bitten by the same mosquitoes. They were treated with conventional antimalarial drugs, such as amodiaquine.

When the new drug was used experimentally to see if it would be curative in patients with malaria, symptoms disappeared and an apparent cure was effected. However, it is too soon, the investigators believe, to say that the drug will be therapeutically effective as well as protective. It is entirely possible that this new antimalarial eliminates the parasite before infection can take root. Studies of this point are underway, but are not complete. The scientists believe that the chemical, when injected, is held in muscle tissues, where it releases its effective materials into the cir-

culating blood to be carried to every part of the body.

Whether the parasites which typically form a reservoir in liver cells are actually killed remains to be determined. No toxic effects have been observed during these studies.

In a separate investigation, a slightly different form of the drug has been tried on 9 volunteers. However, one of them came down with malaria 169 days after the original challenge by the infected mosquito. He had been challenged on the sixth day and again on the 79th day after receiving the drug. None of the volunteers injected with the original formula have shown any evidence of malaria infection. As of October 24, 1962, volunteers in the first group had been free of any evidence of malaria for 333 days.

The preliminary results are termed "spectacular" by some of the investigators, but they caution that it remains to be determined whether these results will be borne out under actual field conditions in malaria areas of the world.

The new drug, CI-501, is the pamoic acid salt of the base 4, 6-diamino-1-(p-chlorophenyl)-1, 2-dihydro-2, 2-dimethyl-s-triazine. This base was reported 11 years ago to be formed in the body from the antimalarial drug chlorguanide.

WHY CERTIFICATION OF ALL ANTIBIOTICS?

Our opposition to the extension of certification of the antibiotics . . . rests in large measure on the fact that the concept of certification violates the basic principle upon which regulatory enforcement of drug standards has stood since the first federal law in this field was enacted in 1906 . . . Antibiotic producers pay the Food and Drug Administration fees totaling nearly $1 million a year to reproduce tests they have already conducted to demonstrate the satisfactory character of the lots in question. These fees must of course show up in the final selling price of the antibiotic, regardless of how dubious is the value of the double check that the certification program provides. It is the position of the U.S.P. Board of Trustees that there is no longer a need for treating antibiotics as a class any differently from other classes of drugs.

IN THE MIND

(Industrial Medicine and Surgery 31:423, September 1962)

The world is made up of people with too much imagination, particularly when it comes to medication, a recent study of the harmless, inactive placebo ("sugar pill") appears to indicate.

To learn more about the extent to which a totally inactive placebo can induce complaints in healthy, normal persons, two Nebraska physicians made a study of adult members of a church group, motivated by a desire to raise money for their church school. The findings dramatically illustrate the power of imagination.

Twenty of 49 persons reported varying degrees of unwanted side effects. These effects increased as the dosage of harmless tablets increased, until some few refused to cooperate further because of the marked disturbances.

These 20 subjects variously reported that they were made tired, drowsy, dizzy, groggy, light headed, weak, nervous; or that visual disturbance, headache, loss of appetite, increased appetite, abdominal cramps or drying of the mouth occurred. At least one person observed difficulty in driving a car as a result of the medication. The most common side effects were those associated with mental depression. The next most common were connected with gastrointestinal disturbances.

Members of the study group had been told by the investigators that they might feel peculiar sensations but that there was nothing dangerous about the "new medication." Each subject took one tablet morning and evening the first day; two, the second; three, the third; four, the fourth; and five, morning and evening, the last day. The tablets were small, uncoated, compressed, white tablets flavored with a trace of quinine.

Long ago Alexander Pope wrote, "The proper study of mankind is man." When it comes to the determination of real side effects from a new and promising medication, possibly Pope's estimate of the situation should be revised.

"It is indeed unfortunate that rabbits and guinea pigs are unable to communicate to investigators when they feel tired and groggy, weak and nervous and are suffering from visual disturbance, all resulting from a totally harmless placebo . . ."

PRESIDENT'S PAGE



With the holiday season still fresh in our memories and the new year just having dawned, it is a good time for all of us to reflect on how much the profession of pharmacy has given us. Think of how much your national, state and local pharmacy organizations have been doing for you over the years, the laws that are yours, the countless services and the advantages that are yours — all because you are a pharmacist.

Take an inventory of yourself and give an honest evaluation of what you have contributed to pharmacy. You want more and better pharmacists, but what have you done to help your college of pharmacy get more students and better facilities and qualified teachers to do a better job? You have taken a lot of the benefits of pharmacy, but what have you put back to help your colleges, your state and national associations?

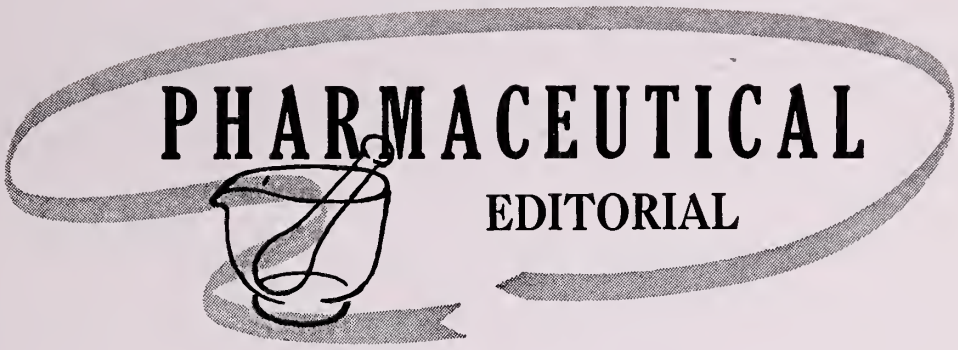
What about your community? Are you putting anything back for the privilege of living in a live, aggressive community — a community with active churches, schools and social clubs?

Your profession and your community can grow bigger and serve you better if you will get behind them with everything you have. You have taken out a lot, now put a little back.

Sincerely,

L. B. Urton

President



APhA PRESIDENT ARCHAMBAULT SEES RISE OF PHARMACY PRACTITIONER

The practitioner of pharmacy as a profession is on the rise here in America declared American Pharmaceutical Association President George F. Archambault at the University of Minnesota recently.

"As President of the APhA, I have had the opportunity to travel widely across this country, in Canada and Puerto Rico. I have been talking and visiting with pharmacists, and, everywhere I go, I find the same encouraging conditions:

"A new keenness for professional activities, a new feeling of the individual's professional worth, a new sense of individual purpose, a new conviction that pharmacy is more than a daily routine or one particular pharmacy."

Dr. Archambault made these points while delivering the Samuel W. Melendy Memorial Lecture, a lecture series established by the late Minnesota pharmacy leader Samuel W. Melendy and given annually by "the most outstanding man in current pharmacy." Besides serving as 1962-63 President of the APhA, the national society of pharmacists, Dr. Archambault is Pharmacy Liaison Officer to the Office of the Surgeon General and Chief, Pharmacy Branch, Division of Hospitals, Bureau of Medical Services, U. S. Public Health Service.

"The pharmacist is better educated, he is more vocal in his views, he is demanding more of himself professionally and also of his organizations, he is a part of and is being affected by broad social, economic, and scientific changes, and, most important, he sees that it is not economic protection, not favorable laws that will give him the future he wants. He sees that his future lies in serving as what he truly is — a trained medication and sick room supply expert—a pharmacist."

Evidence of this new situation in American pharmacy can be seen, Dr. Archambault said, in:

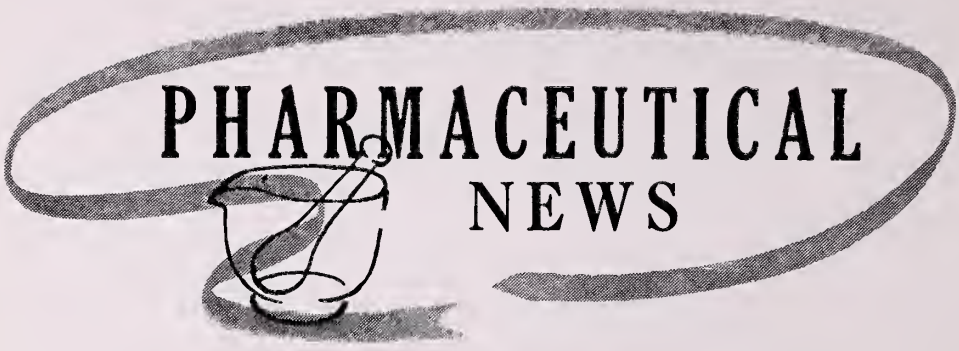
—The unification and affiliation of local, state and national professional societies.

—The increasing use of the professional fee.

—The seeking by pharmacists of more satisfaction from their daily practices. Here, he cited the movement to make every pharmacy a health education center; the need by the public for health advice and guidance from the pharmacist in the purchase of ordinary health items and household medications; advising physicians, dentists and veterinarians on drug properties; and pharmacists' participation in community health projects and programs.

"The outstanding men in current pharmacy are the practicing pharmacists themselves," Dr. Archambault concluded. "On their own, they are enlarging their mental outlook, broadening it as it were, from private entrepeneur to public professional. On their own, they are demanding federation and a voice and a vote in the associations that represent them at the local, state, specialty, and national levels.

"We are indeed seeing the rise of the individual professional in pharmacy — educated, vocal, self-disciplined, and determined to increase his personal satisfaction by developing his professional role to its fullest. We are seeing the first view of the pharmacist of the future."



PHARMACY STUDENTS NAMED TO "WHO'S WHO"

Three pharmacy seniors were among South Dakota State College students selected for listing in the 1962-63 edition of "Who's Who Among Students in American Universities and Colleges."

Announcement of the selections was made by Orlin E. Walder, dean of men and director of student activities at State.

Although scholarship is an important consideration in making the selections, Walder pointed out that "leadership and participation in extracurricular and academic activities, citizenship, service to the school and promise of future usefulness to society" are also prime considerations.

The pharmacy students selected are **Marcia Teig,** Highmore; **David Powell,** Brookings; and **Marlene Wallace,** Britton.

APhA STATEMENT ON PREPAID PRESCRIPTION SERVICE STUDY

For over two years the American Pharmaceutical Association has been studying the practicability of a Prepaid Prescription-Service Program, including the possibility of developing such programs as Blue Cross plans. To assist in this project APhA appointed several advisory committees, one of which included Blue Cross representatives who became interested in the project and have been working with APhA to provide possible approaches to a series of pilot programs.

Drafts of representative documents, as well as procedures and methods for implementing such proposed programs on an individual state basis, have been submitted to the United States Department of Justice for its review and ruling with respect to whether or not there is any conflict with federal antitrust laws.

Work to date is part of a study project and until legal review is completed, further statements would be inappropriate.

AMA GRAPPLES WITH PROBLEM OF PHYSICIAN-OWNED PHARMACIES

The Judicial Council of the American Medical Association urged the AMA House of Delegates to declare the ownership of a pharmacy, a drug packaging company or controlling interest in a pharmaceutical manufacturing company as unethical, but the Reference Committee of the AMA House of Delegates returned it for further study and report.

The Judicial Council reported that "it is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. It is unethical for a physician to own or have an interest in a drug repackaging company under any circumstances. It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the private practice of medicine. These practices are contrary to the best interests of the public and the medical profession. Any arrangement by which the physician profits from the remedy he prescribes or supplies is unethical."

The Reference Committee, after several hours of discussion, returned the proposal to the Judicial Council for additional study, and asked

that such important matters be first published in the Journal of the American Medical Association so that local and state medical societies will have an opportunity of expressing their positions before it is acted upon by the AMA House of Delegates.

The problem was brought directly to the attention of the AMA Judicial Council by APhA, ACA and NARD two years ago. Progress was made at last year's AMA Clinical Session when the AMA House of Delegates adopted a Judicial Council report stating that "rentals by physicians for space leased by them to pharmacists based on a percentage of income are unethical."

In June, 1962, after another meeting with APhA, ACA and NARD, the Judicial Council stated that it can "under no circumstances become unethical and contrary to the best interests of the public and the medical profession for a physician to own a pharmacy."

APhA will continue its efforts to identify the problem of physician-ownership of pharmacies and to gain the desired objective on this point as set forth in the latest recommendation of the Judicial Council, according to a statement by Dr. Apple made at the AMA Clinical Session in Los Angeles. "Pharmacists are eager to resolve this problem at the inter-professional level, and thus avoid it becoming a matter of public controversy," added APhA's Executive Director.

APhA ANNUAL MEETING FORMAT SET

General format of the 110th annual meeting of the **American Pharmaceutical Association,** and affiliated and related organizations is now set. The dates are May 12-17, 1963 and the site is the Americana Hotel in the Bal Harbour section of Miami Beach, Florida.

The over-all format for the 1963 APhA annual meeting will retain the condensed, streamlined pattern that proved so successful during the 1962 Las Vegas meeting. The annual meeting will be officially launched, Sunday evening, May 12 with an opening session followed by a reception for President and Mrs. George F. Archambault. APhA general sessions are set for Monday afternoon, May 15, with world-renowned speakers featured at each session; the final general session Friday morning, May 17 will wind up the five-day meeting.

APhA House of Delegates sessions are conveniently scheduled during the annual meeting to provide the maximum time for delegates to receive reports and to discuss the problems facing the profession. A special session of this policy-making body will be held Monday evening, May 13, to be devoted exclusively to discussion of vital issues.

Seven sections will fit full programs into the five days in such a way as to provide a minimum of competition with the affiliated and related organizations also meeting during the week at the Americana. For example, the recently established **Section on the General Practice of Pharmacy,** whose program will be geared to the practicing community pharmacist, will be supplemented by meetings of the **American College of Apothecaries.**

Pharmaceutical scientists and educators will have an opportunity to learn the latest development in research during the eight scheduled sessions of the **Scientific Section,** including several symposia on topics of vital interest. Similarly, pharmacists in industry, military pharmacists, pharmaceutical historians, educators and those particularly interested in pharmaceutical technology, and pharmacy students will meet in their own sections.

The **American Society of Hospital Pharmacists** will convene their annual meeting on Monday morning, May 13, which will include two sessions on Tuesday, May 14, a joint session with the American College of Apothecaries on Wednesday morning, May 15, a banquet Wednesday evening and a final session on Thursday morning, May 16. Other ACA meetings will be held on Tuesday morning, May 14, and Thursday morning, May 16. Annual dinners of both ASHP and ACA are set for Wednesday evening, May 15.

The **National Association of Boards of Pharmacy** will hold their 59th annual meeting on Monday, May 13 and Tuesday, May 14, while the **National Conference of State Pharmaceutical Association Secretaries** meet the weekend immediately preceding

the APhA annual meeting. Meeting during the week also will be the **American Institute of the History of Pharmacy** and the **Metropolitan Drug Association Secretaries.**

Activities of the **APhA Women's Auxiliary** and general entertainment plans are being finalized by the Local Arrangements Committee under the chairmanship of Freeman Oikle of Miami, Florida.

THIRD N.F. INTERIM REVISION ANNOUNCEMENT IS RELEASED

The third interim revision announcement to N.F. XI has been issued by the Committee on National Formulary and approved by the Council of the American Pharmaceutical Association. It becomes effective on February 1, 1963.

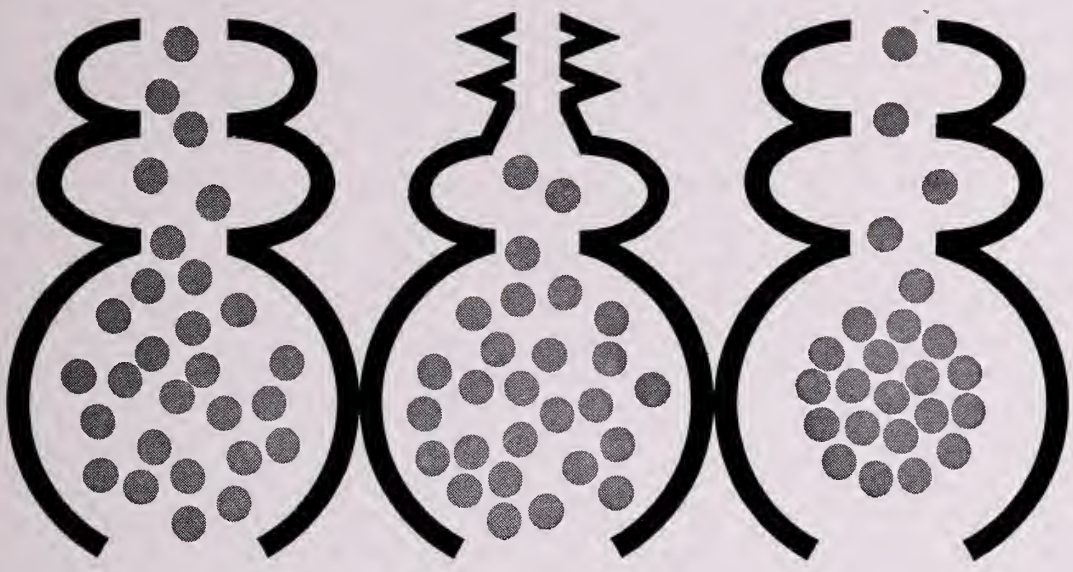
The Director of N.F. Revision, Dr. Edward G. Feldmann, calls particular attention to several antibiotic revisions included in this interim revision announcement. The continuing scrutiny of current standards, as well as the program for the development of new ones, has led to a number of changes in the monographs for Gramicidin and Tyrothricin.

Twenty-two N.F. XI monographs are revised along with several changes in the general tests section. Publication of the interim revision changes is another step in the efforts of the N.F. Committee to give prompt attention to present drug requirements.

The complete text of the announcement was published in the December, 1962 issue of the Journal of Pharmaceutical Sciences. Single copies of the N.F. XI Interim Revision Announucement are available at no charge by addressing a request to the Scientific Division, American Pharmaceutical Association, 2215 Constitution Avenue, N. W., Washington 7, D. C.

THREAT TO NEW DRUG RESEARCH

It has been the experience of my company that the cost of development of a new drug for marketing is approximately five million dollars. I might add that the cost of other major pharmaceutical houses is about the same as our. If it is made more difficult and more costly to bring new drugs to market because of added red tape and restrictions — if a new drug can be barred because of conflicting views, honestly held but involving subjective judgments on its effectiveness — research is seriously threatened and indeed may be effectively foreclosed in the case of drugs for serious diseases which are not highly prevalent. It is vitally important that development of new products of potential public significance not be shut off for such reasons, for the result will be to hamper seriously progress in the conquest of disease and the prolongation of life. — Theodore G. Klumpp, M.D., President, Winthrop Laboratories, to House Interstate and Foreign Commerce Committee, August 20, 1962.



lowers motility | relieves cramping | stops diarrhea

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Dosage: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

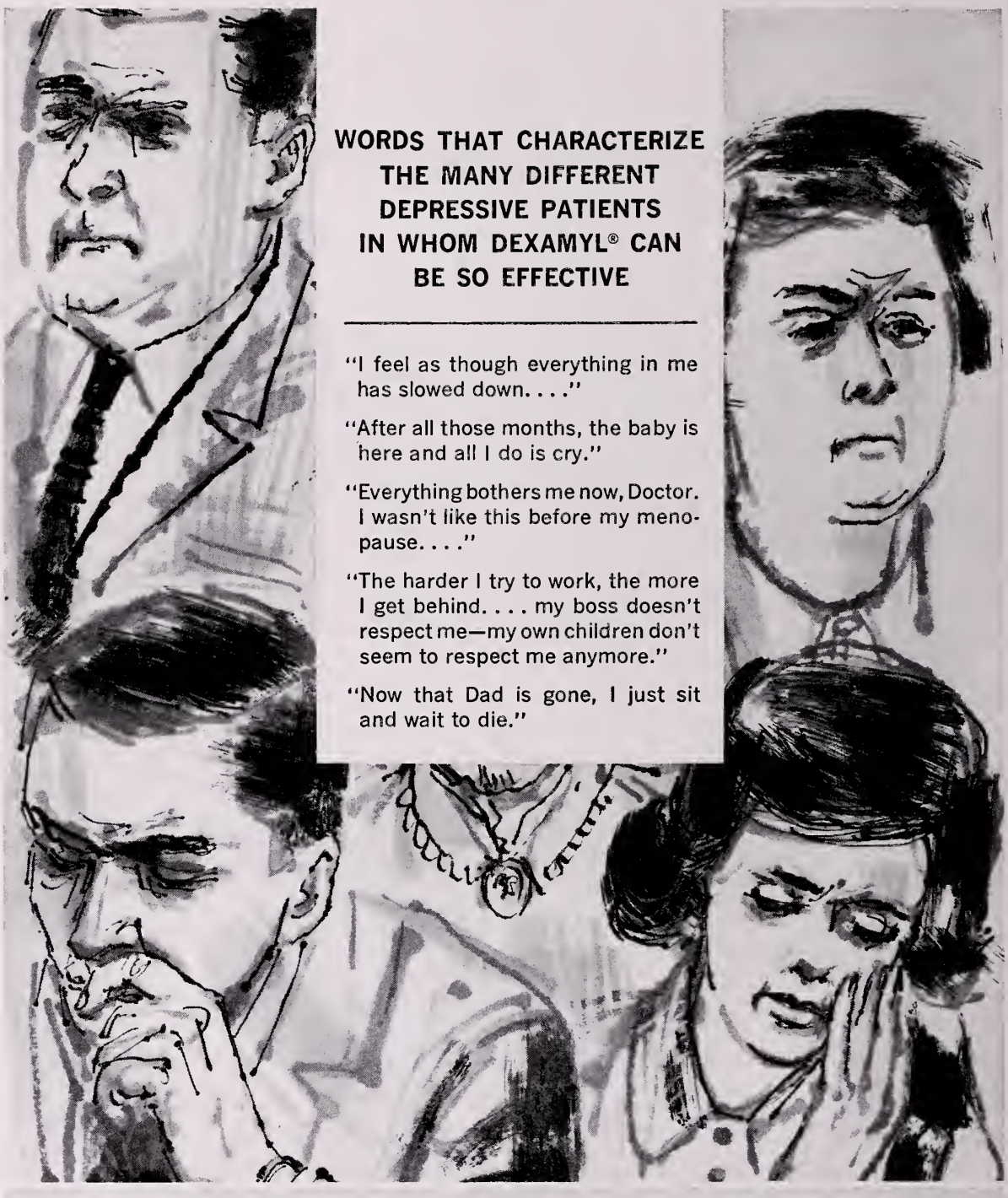
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Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. I. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.

2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22:600-604 (Dec.) 1961.

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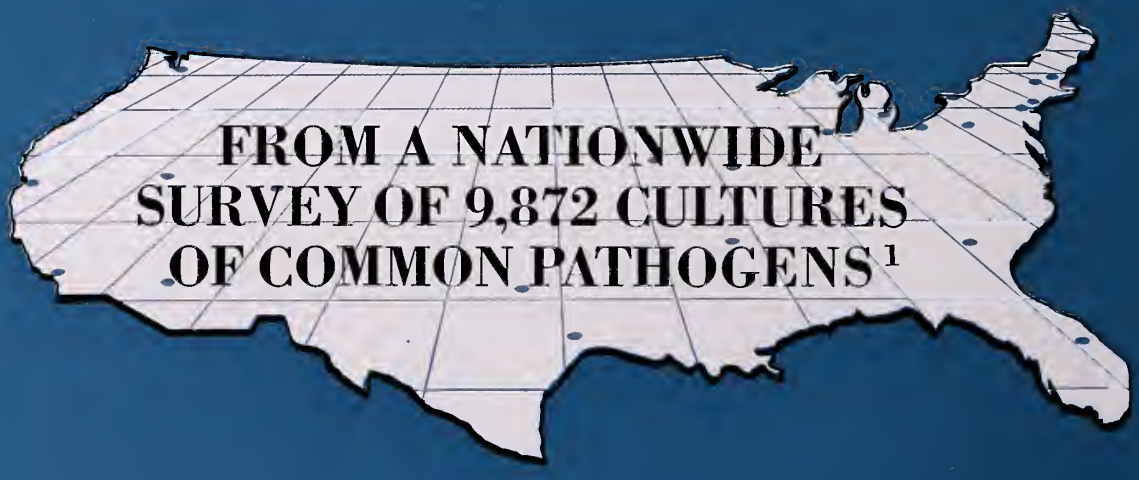
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*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

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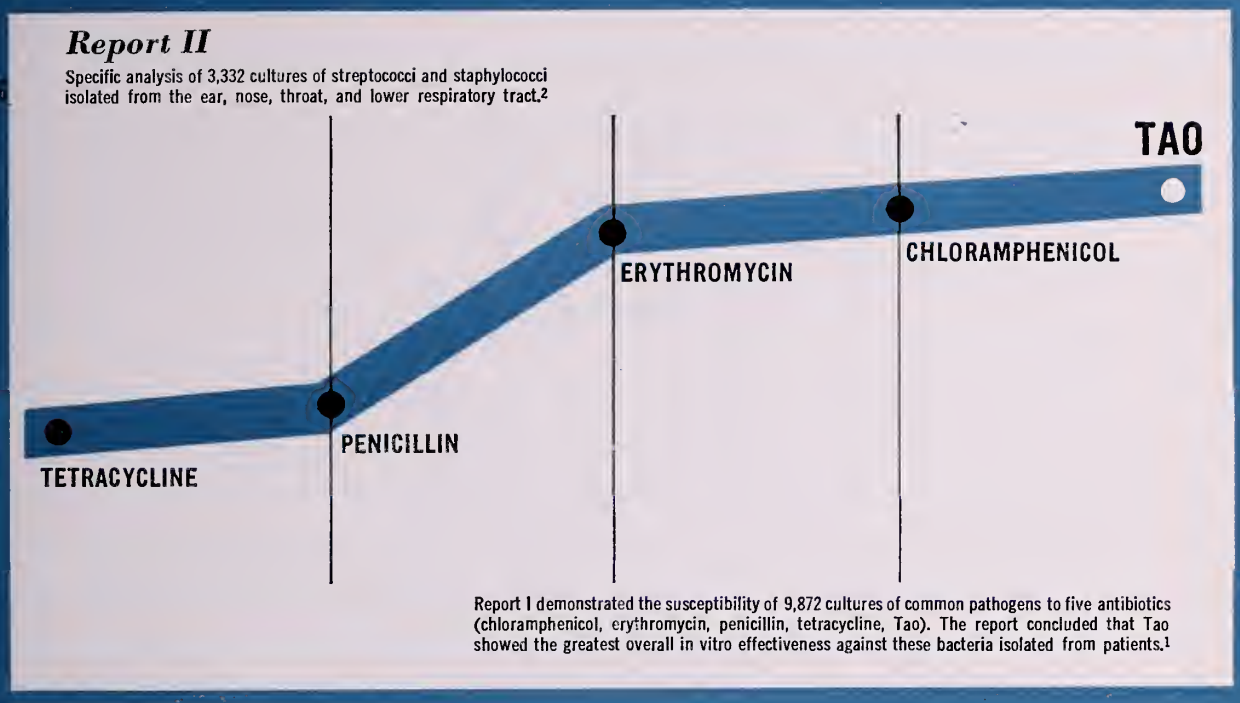


Conclusions of Nationwide Survey: *Report I*

1. **Even after five years of general use,** Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. **Overall results showed a higher percentage of susceptibility** among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. **Tao has been used for five years without development of predictable cross resistance.** In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

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1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. Englisb, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. Englisb, A. R., and Fink, F. C.: Antibiot. and Cbemother. 11:648 (Oct.) 1961.

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1. Borota, A., and Grinell, R. N.: J. Amer. Geriatrics Soc., 10:413, 1962.
2. Spoor, H. J.: N. Y. State J. M. 58:3292, 1958.
3. Lubowe, I. I.: Western Med. 1:45, 1960.
4. Weissberg, G.: Clin. Med. 7:1161, 1960.



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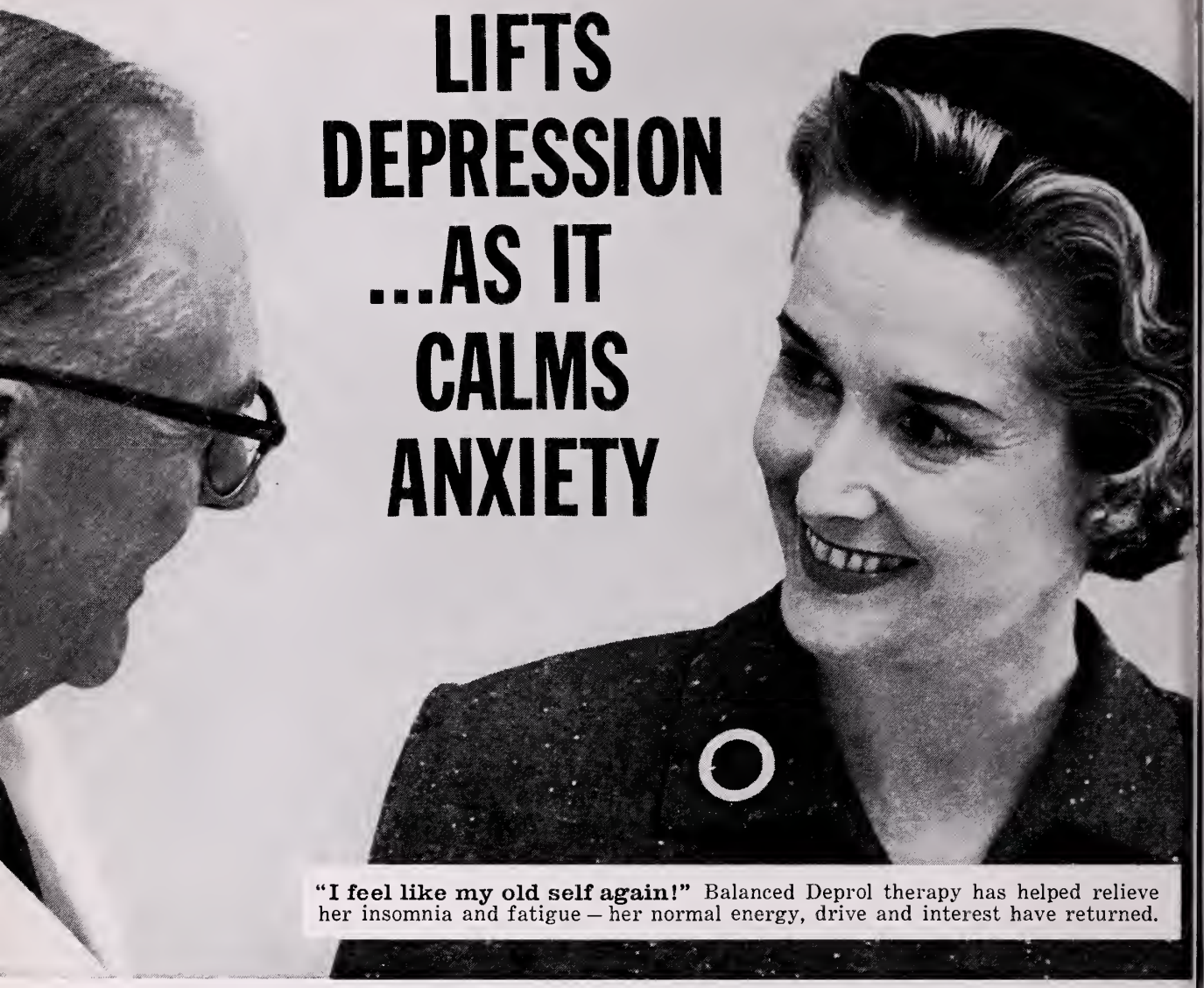
*Levin, S. J.: **Pediat. Clin. North America** 1:975, Nov., 1954.

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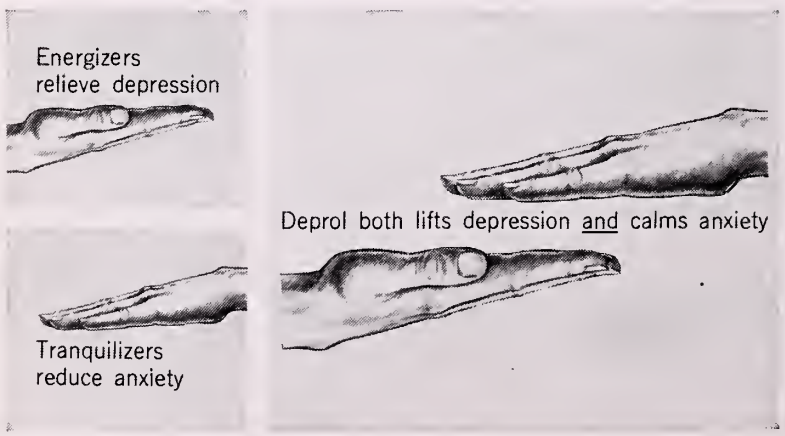
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References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

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Volume XVI **February, 1963** **Number 2**

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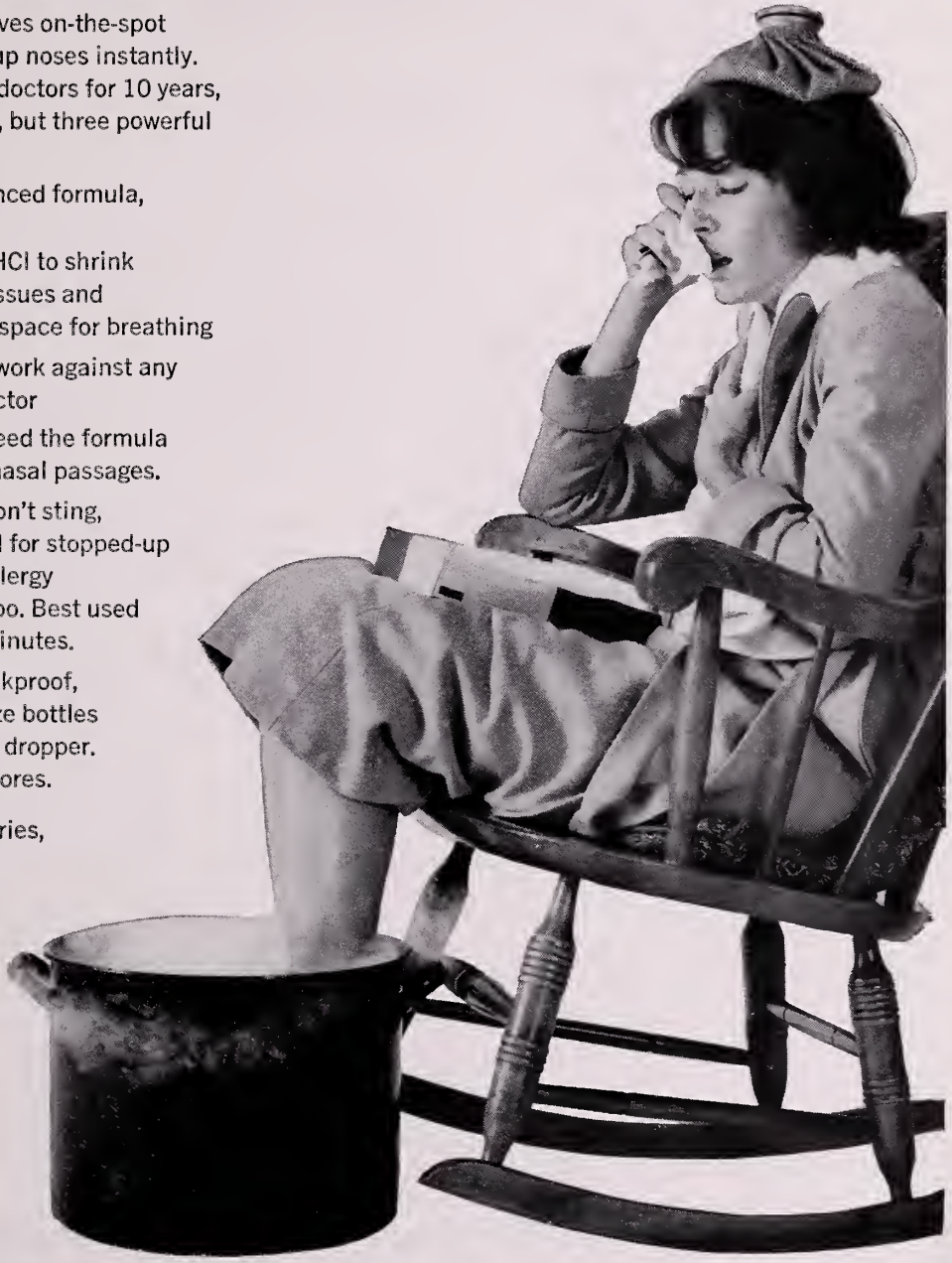
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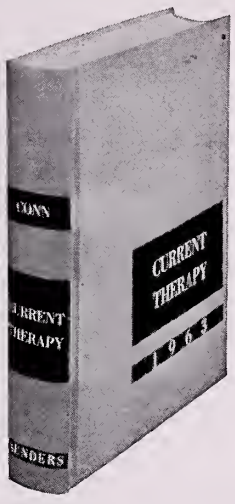
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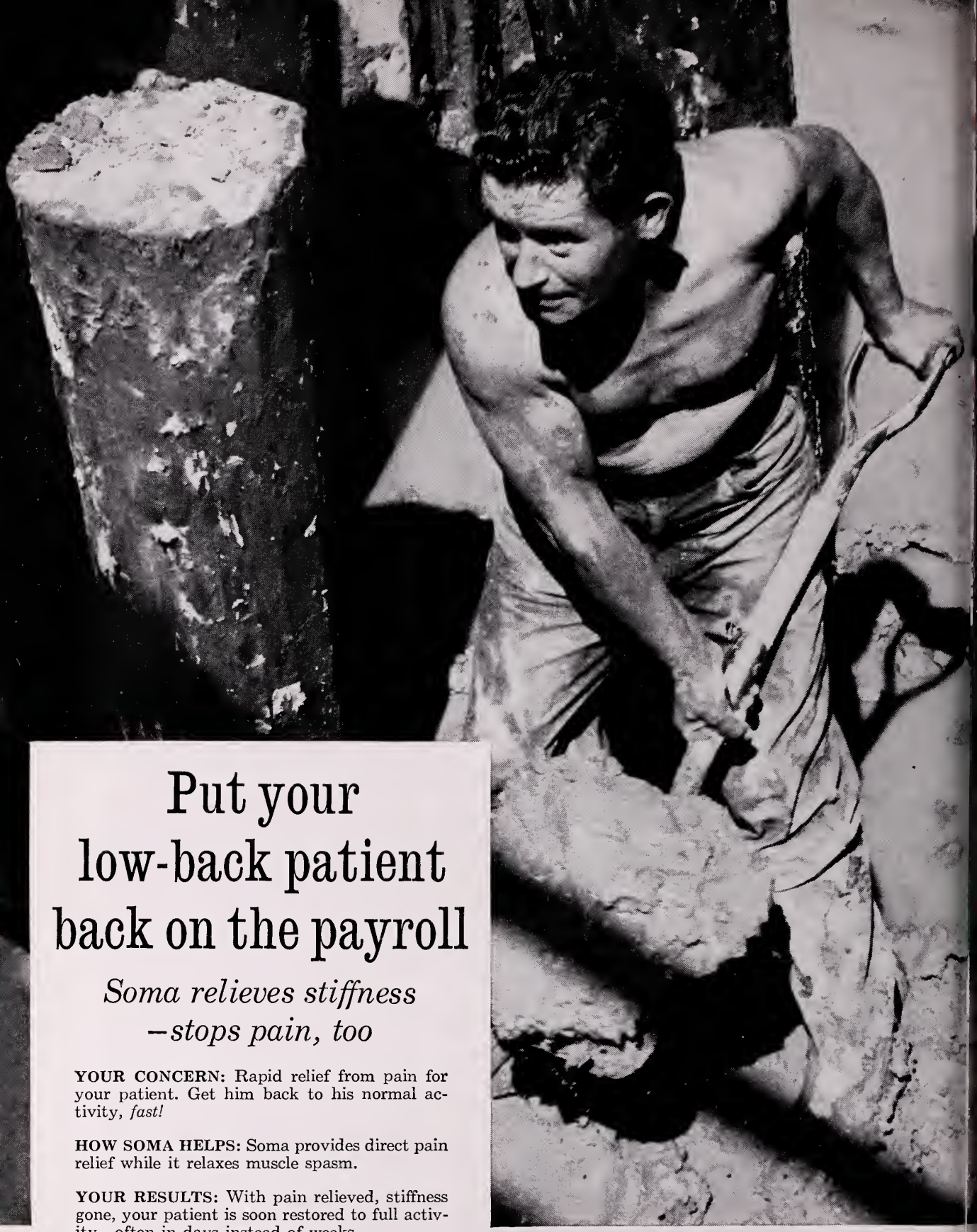
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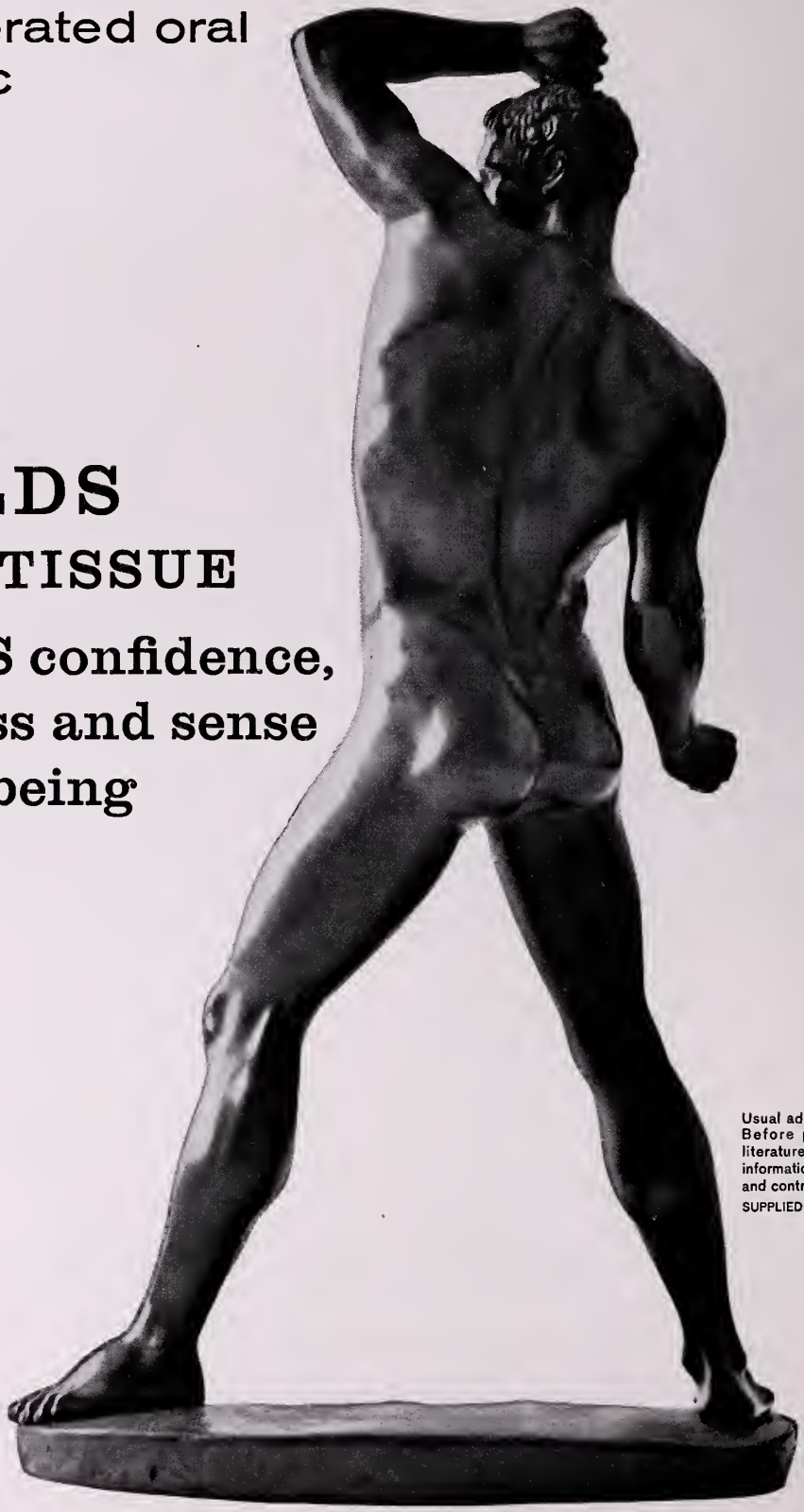
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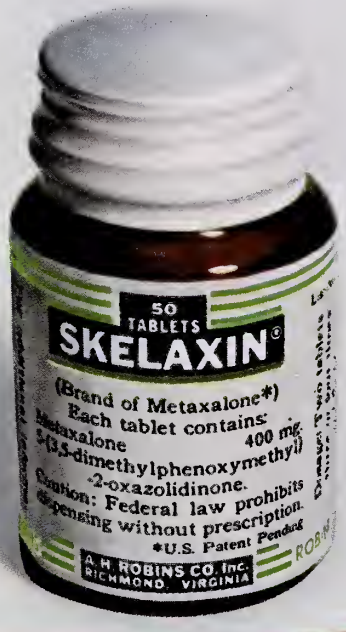
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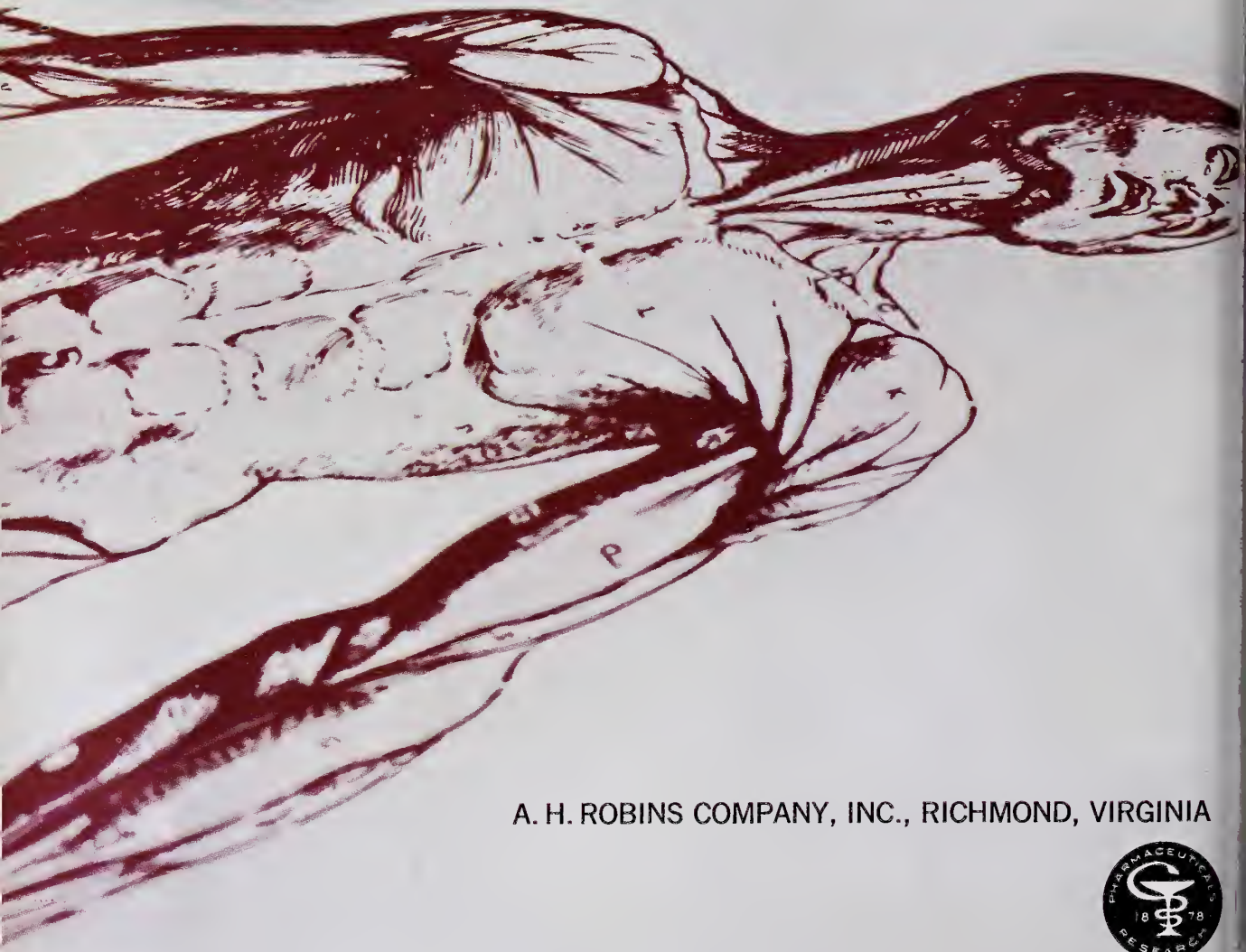
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*Clinical report on file, Medical Dept., A. H. Robins Co., Inc.

A new, chemically different, skeletal muscle relaxant from Robins:

Skelaxin® brand of metaxalo for prompt relief of spasm





A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA

in acute sprains and strains

Because it acts so promptly, often within a few hours, Skelaxin is specifically recommended for the first treatment of acute muscle spasm associated with sprains and strains, fractures, dislocations, and other acute conditions. Results of clinical tests are impressive. In 595 patients with acute disorders, a favorable clinical response was observed in 507, or 85%.

For some of these patients, the onset of relief from pain was exceptionally prompt. Also, the average recovery time of good-or-excellent-response patients (among those whose recovery time was noted) was just over three days.

How Skelaxin works...

Metaxalone has been studied pharmacologically since 1958. Clinical trials began about a year later. These investigations indicate that Skelaxin blocks reflex spasm and spasticity by suppressing nerve impulses in polysynaptic pathways, primarily in the spinal cord and to a lesser degree at supraspinal levels. It helps restore normal muscle tone without altering posture or gait and without producing sedative, hypnotic, or tranquilizing side effects.

For your prescription...

Robins' metaxalone is available in 400-mg. tablets, in bottles of 50 and 500 tablets.

Skelaxin® metaxalone, 400 mg. per tablet

A. H. Robins Company, Inc., Richmond, Va.

prescribing information:

dosage: For Skelaxin, two tablets t.i.d. or q.i.d. for not longer than 10 days. Dosage for children (6 to 12 years) should be adjusted according to body weight.

side effects: In 1502 patients given daily doses of Skelaxin ranging from 1200 to 9600 mg., 10.5% experienced side effects. These were generally mild, with nausea or gastrointestinal upset being most frequent. Only 0.5% experienced vomiting attributable to the drug, however. Other effects infrequently noted were drowsiness, dizziness, headache, nervousness or "irritability," and a hypersensitivity reaction of light rash. All cleared promptly upon withdrawal of the drug.

precautions: Variations in white cell count and hemoglobin levels have been reported in a few patients. Therefore Skelaxin therapy for more than 10 days is not recommended. A drug relationship was indicated in one of four cases of leukopenia reported in 360 Skelaxin-treated patients. In all cases followed-up, the WBC returned to normal after discontinuance of Skelaxin.

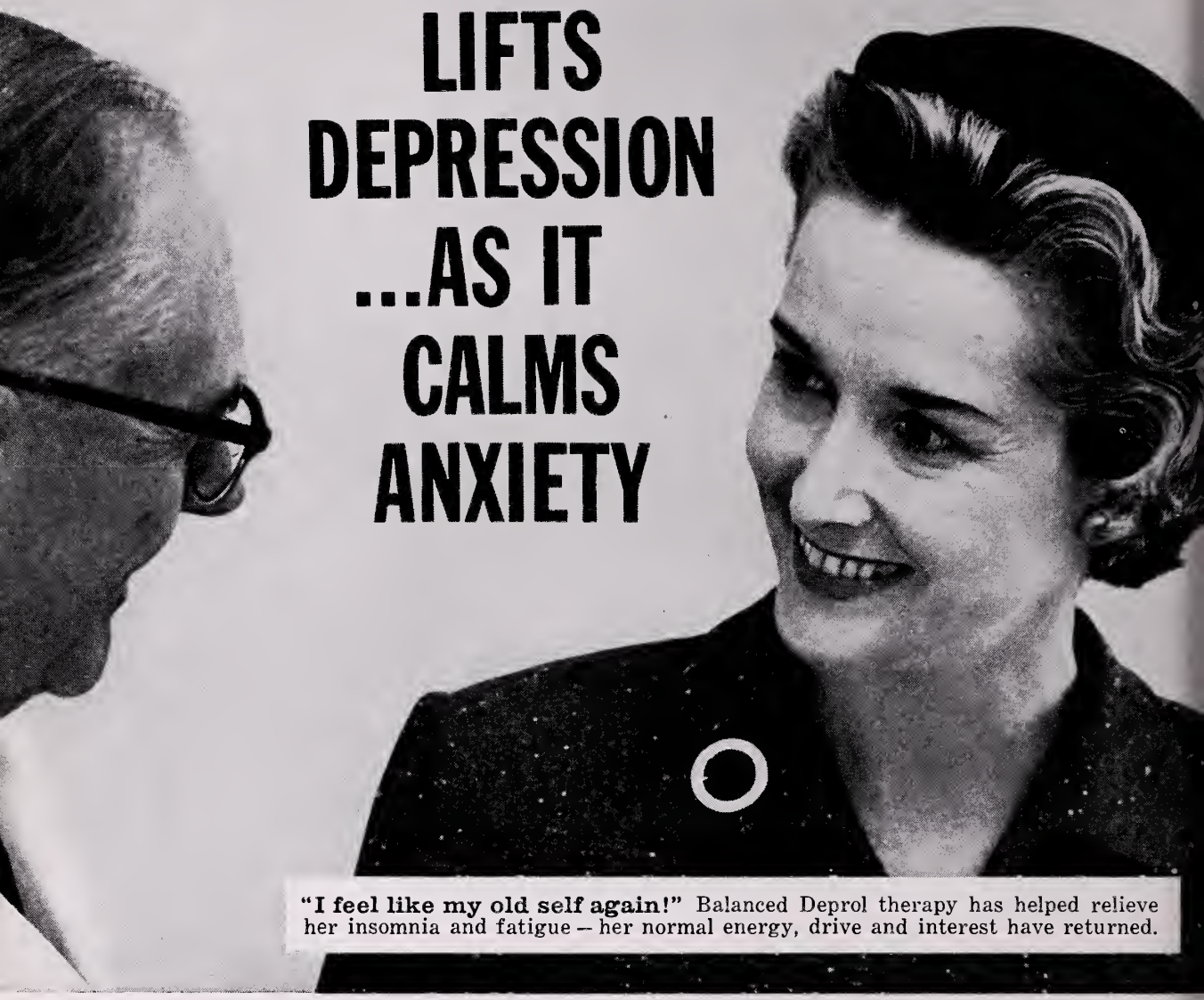
One instance of hemoglobin depression (less than 10 Gm.) which may have been drug-related was reported, in 306 patients; a return to an essentially normal level followed the discontinuance of medication.

One case of jaundice has been reported. Elevation of cephalin flocculation tests in several instances were not paralleled by changes in other liver function parameters. Urinalyses in 280 patients were essentially normal; false positive Benedict's tests, due to an unknown reducing substance in the urine, were reported in 9 patients.

contraindications: Do not administer to patients with known tendency to drug-induced anemia, or give to them only under careful supervision. Not recommended for use during pregnancy.

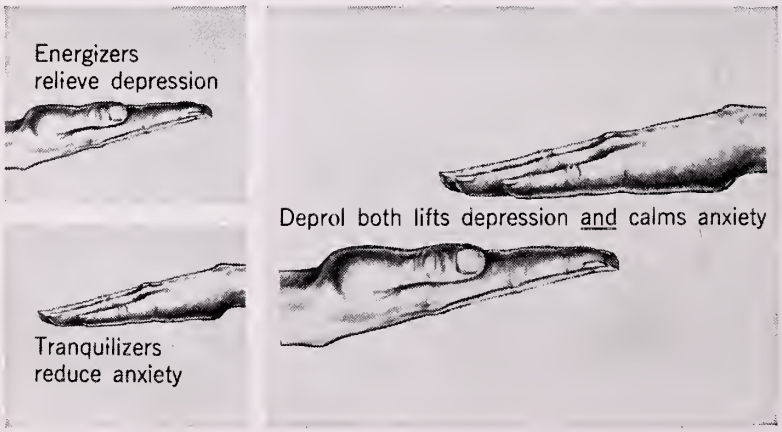
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"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylominoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

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'METHEDRINE'®

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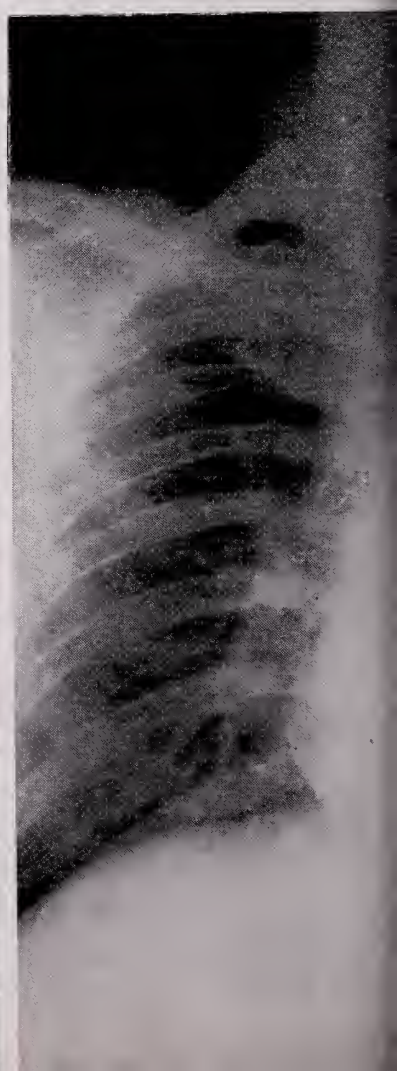
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DECLOMYCIN produces activity levels higher than those of other tetracyclines...at lower dosage...and maintains them during the entire course of treatment without significant fluctuation.

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Over the wide range of everyday infections—respiratory, urinary and most others—in the young and the aged—the acutely or chronically afflicted—DECLOMYCIN provides the "extra dimension" in broad spectrum control.

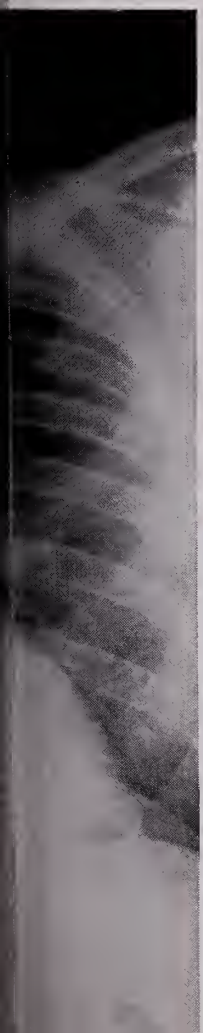
the decision is for

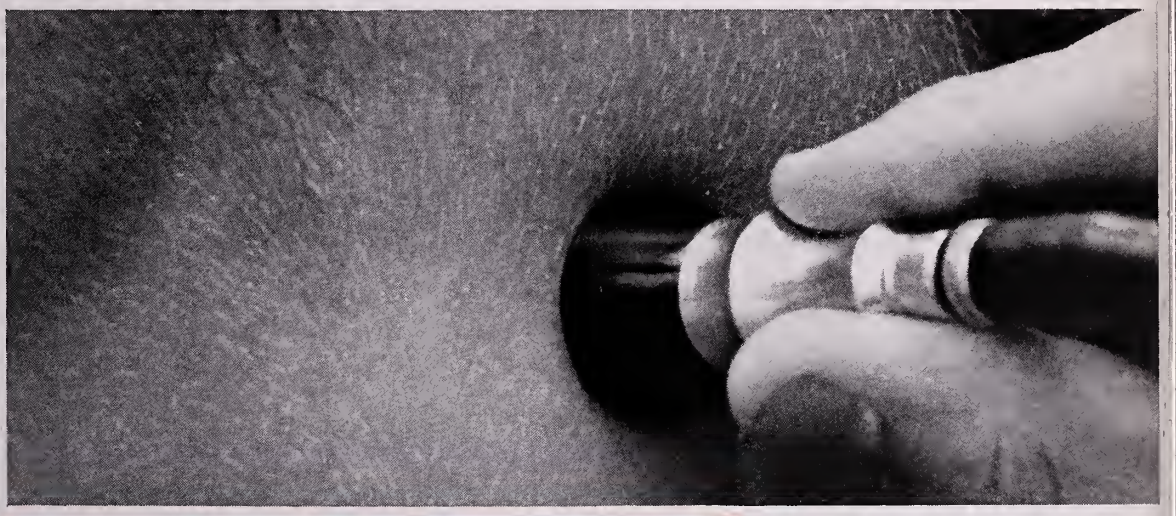
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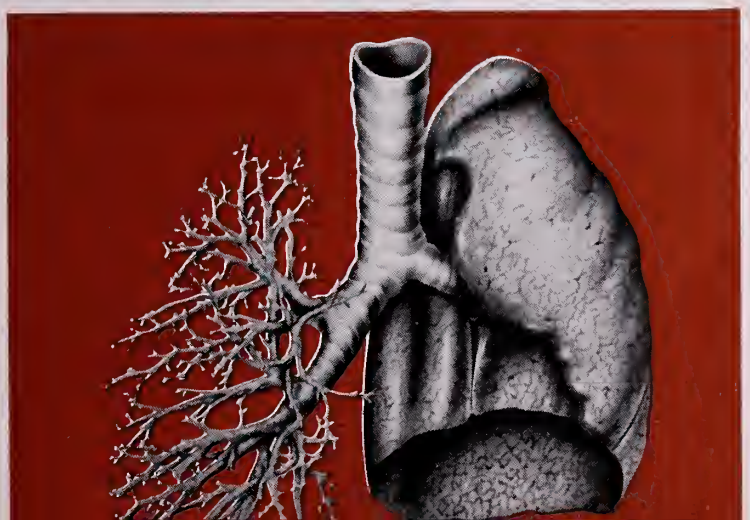
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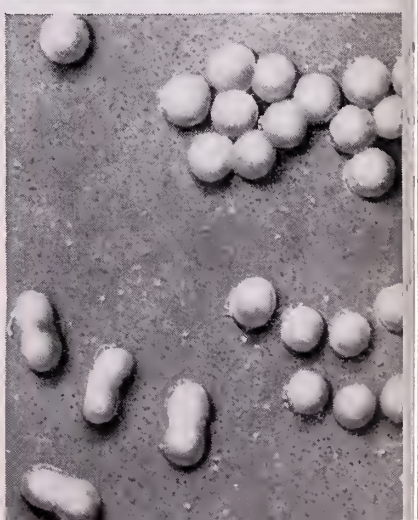
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Let's Start Raising Hell*

By

Jenkin Lloyd Jones, Tulsa, Oklahoma

Long before the prophet, Jeremiah, uttered his lamentation about the evil behavior of the Children of Israel, the world had seen many calamity-howlers. We have cuneiform tablets describing the moral decay of Babylon and Chaldea. We have hieroglyphic inscriptions predicting that Osiris and Ra will smite the Egyptians for their wickedness. And so when I rise today and make some comments about the moral climate of America, and about our responsibilities therefor as temporary custodians of America's press, I speak in a very old tradition.

The calamity howler! It is customary to dismiss such fogeyism as I am about to display with a tolerant laugh. For while it was freely predicted all through the ages that the world was going to Hell, it hasn't gone to Hell yet. Who can deny that in practically all the crafts and certainly all the sciences we are farther advanced than we ever have been? Why not be cheerfully optimistic?

I think I can tell you why. Human progress has never been steady. It has washed back and forth like waves upon a beach. Happily, there has also been an incoming tide, so the waves have washed higher and higher as each great civilization came on.

But the pathway of history is littered with the bones of dead states and fallen empires. And they were not, in most cases, promptly replaced by something better. Nearly a thousand years elapsed between the fall of Western Rome and the rise of the Renaissance, and in between we had the Dark Ages in which nearly all of man's institutions were inferior to those which had gone before. I don't want my children's children to go through a couple

* This is the text of an address Mr. Jones gave at the Alabama Press Association convention in Birmingham, February 9. Reprinted from July issue of **Colorado Editor.**

of centuries of dialectic materialism before the sun comes up again.

So the Jeremiahs haven't been so wrong, after all. It is sad to watch the beginnings of decay. It is sad to see an Age of Pericles replaced by the drunken riots of Alcibiades. There was, indeed, just cause for gloom when into the palaces of the Caesars went Nero and Caligula, and when the once-noble Praetorian Guard became a gang of assassins willing to sell the throne to the highest bidder.

Alaric's Goths finally poured over the walls of Rome. But it was not that the walls were low. It was that Rome, itself, was low. The sensual life of Pompeii, the orgies on Lake Trasimene, the gradually weakened fibre of a once self-disciplined people that reduced them at last to seeking safety in mercenaries and the payment of tribute—all these brought Rome down. She went down too early. She had much to teach the world.

We have much to teach

And so, ladies and gentlemen, I look upon our own country and much that I see disturbs me. But we are a great people. We have a noble tradition. We have much to teach the world, and if America should go down soon it would be too early.

One thing is certain. We shall be given no centuries for a leisurely and comfortable decay. We have an enemy now—remorseless, crude, brutal and cocky. However much the leaders of the Communist conspiracy may lie to their subjects about our motives, about our conditions of prosperity, about our policies and aims, one thing they believe themselves implicitly — and that is that we are in an advanced state of moral decline.

When Nikita Khrushchev visited Hollywood he was shown only one movie set, that of a wild dance scene in Can-Can. He said it represented decadence and I am sure he really thought so. It is a dogma of current Communist faith that America is Sodom and Gomorrah, ripening for the kill.

Do you know what scares me about the Communists? It is not their political system, which is primitive and savage. It is not their economic system, which works so badly that progress in a few directions is purchased at the price of progress in all the rest. It is their puritanism. It is their dedication and self-sacrifice.

It does no good to comfort ourselves with the reflection that these are products of endless brainwashings, of incessant propaganda, of deprivation by censorship and jamming of counter-information and contrary arguments. The dedication is there. The confidence that they are morally superior is there.

The naive questions of your In-tourist guide reveal only too quickly that she is talking to a self-indulgent fop from the court of some latter-day Louis XIV. In the school yard the children rush up to show you, not their yo-yos, but their scholarship medals. And when you offer them new Lincoln pennies as souvenirs they rip off their little Young Pioneer buttons and hand them to you, proud that they are not taking gifts, but are making a fair exchange.

The Russian stage is as austere as the Victorian stage. Russian literature may be corny but it is clean, and it glorifies the Russian people and exudes optimism and promise. Russian art is stiffly representational, but the paintings and the sculpture strive to depict beauty and heroism—Russian beauty, of course, and Russian heroism.

And what of us?

Well, ladies and gentlemen, let's take them one at a time.

For us: life adjustment

We are now at the end of the third decade of the national insanity known as "progressive education." This was the education where everybody passes, where the report cards were noncommittal lest the failure be faced with the fact of his failure, where all moved at a snail pace like a transatlantic convoy so that the slowest need not be left behind, and all proceeded toward adulthood in the lockstep of "togetherness." Thus the competition that breeds excellence was to be sacrificed for the benefit of something called "life adjustment."

With what results? We have watched juvenile delinquency climb steadily. We have produced tens of thousands of high school graduates who move their lips as they read and cannot write a coherent paragraph. While our Russian contemporaries, who were supposed to be dedicated to the mass man, have been busy constructing an elite we have been engaged in the wholesale production of mediocrity. What a switch!

When was the last time you, as editors

and publishers, examined the curricula of your local schools? How did your schools rank on the standardized Iowa tests? When have you looked at your schools' report cards and the philosophy behind their grading system? Have you asked to examine any senior English themes? Have you offered any recognition to your schools' best scholars to compare with the recognition you accord your schools' best football players?

For the funny thing about "progressive educators" is that theory vanishes when the referee's whistle blows for the kickoff. In the classroom they pretend to grade subjectively, against the student's supposed capacity, lest he be humiliated by natural inadequacy. But on the football field they never put in a one-legged halfback on the theory that, considering his disability, he's a great halfback. They put in the best halfback they've got, period. The ungifted sit on the bench or back in the stands even though they, too, might thirst for glory. If our schools were as anxious to turn out brains as they are to turn out winning football teams this strange contradiction wouldn't exist.

Discipline rejected

Having neglected discipline in education it was quite logical that we should reject disciplines in art. The great painters and sculptors of the past studied anatomy so diligently that they often indulged in their own body-snatching. And today, after many centuries, we stare at the ceiling of the Sistine Chapel or at the walls of the Reichsmusee and marvel at their works.

But this self-discipline is of little concern to the modern nonobjective painter. All he needs is pigment and press agent. He can throw colors at a canvas and the art world will discover him. He can stick bits of glass, old rags, and quids of used chewing tobacco on a board and he is a social critic. He can drive a car back and forth in pools of paint and Life magazine will write him up.

Talent is for squares. What you need is vast effrontery. If you undertake to paint a cow it must look something like a cow. That takes at least a sign-painter's ability. But you can claim to paint a picture of your psyche and no matter what the results, who is to say what your psyche looks like? So our museums are filled with daubs being stared at by confused citizens who haven't the guts to admit they are confused.

But the Age-of-Fakery in art is a mild cross that American civilization bears. Much more serious is our collapse of moral standards and the blunting of our capacity for righteous indignation.

Our Puritan ancestors were preoccupied with sin. They were too preoccupied with it. They were hag-ridden and guilt-ridden and theirs was a repressed and neurotic society. But they had horsepower. They wrested livings from rocky land, built our earliest colleges, started our literature, found time in between to fight the Indians, the French and the British, to bawl for abolition, women's suffrage and prison reform, and to experiment with graham crackers and bloomers. They were a tremendous people.

And for all their exaggerated attention to sin, their philosophy rested on a great granite rock. Man was the master of his soul. You didn't have to be bad. You could and should be better. And if you wanted to escape the eternal fires you'd damned well better be.

Sin is imaginary

In recent years all this has changed in America. We have decided that sin is largely imaginary. We have become enamoured with "behavioristic psychology." This holds that a man is a product of his heredity and his environment, and his behavior to a large degree is foreordained by both. He is either a product of a happy combination of genes and chromosomes or an unhappy combination. He moves in an environment that will tend to make him good or that will tend to make him evil. He is just a chip tossed helplessly by forces beyond his control and, therefore, not responsible.

Well, the theory that misbehavior can be cured by pulling down tenements and erecting in their places elaborate public housing is not holding water. The crime rates continue to rise along with our outlays for social services. We speak of underprivilege. Yet the young men who swagger up and down the streets, boldly flaunting their gang symbols on their black jackets, are far more blessed in creature comforts, opportunities for advancement, and freedom from drudgery than 90 per cent of the children of the world. We have sown the dragon's teeth of pseudoscientific sentimentality, and out of the ground has

sprung the legion bearing switch-blade knives and bicycle chains.

Clearly something is missing. Could it be what the rest of the world's children have been given — the doctrine of individual responsibility?

Relief is gradually becoming an honorable career in America. It is a pretty fair life, if you have neither conscience nor pride. The politicians will weep over you. The state will give a mother a bonus for her illegitimate children, and if she neglects them sufficiently she can save enough out of her ADC payments to keep herself and her boy friend in wine and gin. Nothing is your fault. And when the city fathers of a harassed community like Newburgh suggest that able-bodied welfare clients might sweep the streets the "liberal" editorialists arise as one man and denounce them for their medieval cruelty.

I don't know how long Americans can stand this erosion of principle. But I believe that some of my starry-eyed friends are kidding themselves when they pretend that every planeload of Puerto Ricans that puts down at Idlewild is equivalent in potential to every shipload of Pilgrims that put into old Plymouth. Nations are built by people capable of great energy and self-discipline. I never heard of one put together by cha-cha-cha.

The welfare state that taxes away the rewards of responsible behavior so that it can remove the age-old penalties for irresponsible behavior is building on a foundation of jelly. It is time we stopped this elaborate pretense that there is no difference between the genuinely unfortunate and the mobs of reliefers who start throwing bottles every time the cops try to make a legitimate arrest.

Finally, there is the status of our entertainment and our literature.

Dirt, alias realism

Can anyone deny that movies are dirtier than ever? But they don't call it dirt. They call it "realism." Why do we let them fool us? Why do we nod owlishly when they tell us that filth is merely a daring art form, that licentiousness is really social comment? Isn't it time we recognized Hollywood's quest for the fast bucks for what it is? Isn't it plain that the financially harassed movie industry is putting gobs of sex in the darkened drive-ins in an effort to lure curious teenagers away from their TV sets? Last week the screen industry solemnly announced that henceforth perversion and homosexuality would no longer be barred from the screen provided the subjects were handled with "delicacy and taste." Good Lord!

And we of the press are a party to the crime.

Last year the movie ads in our newspaper got so salacious and suggestive that the advertising manager and I decided to throw out the worst and set up some standards. We thought that due to our ukase there might be some interruption in advertising some shows. But no. Within a couple of hours the exhibitors were down with much milder ads. How was this miracle accomplished?

Well, it seems that the exhibitors are supplied with several different ads for each movie. If the publishers are dumb enough to accept the most suggestive ones those are what they get.

But if publishers squawk the cleaner ads are sent down. Isn't it time we all squawked?

I think it's time we quit giving page 1 play to extra-marital junkets of crooners. I think it is time we stopped treating as glamorous and exciting the brazen shack-ups of screen tramps. I think it is time we asked our Broadway and Hollywood columnists if they can't find something decent and inspiring going on along their beats.

And the stage: They raided Minsky's so Minsky's has spread all over town. Bawdiness has put on a dinner jacket, and seats in the orchestra that used to go for six-bits at the old Howard and Nichols' Gayety are now scaled at $8.80. Oh, yes. And we have lots of "realism." Incestuous Americans. Perverted Americans. Degenerate Americans. Murderous Americans.

How many of these "realistic" Americans do you know?

Two months ago an American touring company, sponsored by the State Department and paid for by your tax dollar, presented one of Tennessee Williams' more depraved offerings to an audience in Rio de Janeiro. The audience hooted in disgust and walked out. And where did it walk to? Right across the street where a Russian ballet company was putting on a beautiful performance for the glory of Russia! How dumb can we get?

We are drowning our youngsters in vio-

lence, cynicism and sadism piped into the living room and even the nursery. The grandchildren of the kids who used to weep because the Little Match Girl froze to death now feel cheated if she isn't slugged, raped and thrown into a Bessemer converter.

Nations have souls

And there's our literature. The old eye-poppers of the past, which tourists used to smuggle back from Paris under their dirty shirts are now tame stuff. Compared to some of our modern slush, "Ulysses" reads like the minutes of the Epworth League. "Lady Chatterly's Lover" has been draped with the mantle of art, and it is now on sale in the corner drugstore to your high-school-age son or daughter for 50c. Henry Miller's "Tropic of Cancer," which resembles a collection of inscriptions taken from privy walls, is about to join Lady Chatterly. The quick-buck boys have apparently convinced our bumfuzzled judges that there is no difference between a peep show and a moral lecture.

Don Maxwell of the Chicago Tribune has recently asked his book department to quit advertising scatological literature by including it in the list of best sellers. The critics and the book publishers have denounced him for tampering with the facts. I would like to raise a somewhat larger question: Who is tampering with the soul of America?

For nations do have souls. They have collective personalities. People who think well of themselves collectively exhibit elan and enthusiasm and morale. When nations cease believing in themselves, when they regard their institutions with cynicism and their traditions with flippancy they will not long remain great nations. When they seek learning without effort and wages without work they are beginning to stagger. Where they become hedonistic and pleasure-oriented, when their Boy Scouts on their 14-mile hikes start to hitch, there's trouble ahead. Where payola becomes a way of life, expense account cheating common, and union goonery a fiercely defended "right," that nation is in danger. And where police departments attempt to control burglary by the novel method of making it a department monopoly then the chasm yawns.

Ladies and gentlemen: do not let me overdraw the picture. This is still a great, powerful, vibrant, able, optimistic nation. Americans—our readers—do believe in themselves and in their country.

But there is rot and there is blight and there is cutting out and filling to be done if we, as the leader of free men, are to survive the hammer blows which quite plainly are in store for us all.

Duty of the press

We have reached the stomach-turning point. We have reached the point where we should re-examine the debilitating philosophy of permissiveness. Let this not be confused with the philosophy of liberty. The school system that permits our children to develop a quarter of their natural talents is not a champion of our liberties. The healthy man who chooses to loaf on unemployment compensation is not a defender of human freedom. The playwright who would degrade us, the author who would profit from pandering to the worst that's in us, are no friends of ours.

It is time we hit the sawdust trail. It is time we revived the idea that there is such a thing as sin—just plain old willful sin. It is time we brought self-discipline back into style. And who has a greater responsibility at this hour than we, the gentlemen of the press?

So I suggest:

Let's look to our educational institutions at the local level, and if Johnny can't read by the time he's ready to get married let's find out why.

Let's look at the distribution of public largesse and if, far from alleviating human misery, it is producing the sloth and irresponsibility that intensifies it, let's get it fixed.

Let's quit being bulldozed and bedazzled by self-appointed longhairs. Let's have the guts to say that a book is dirt if that's what we think of it, or that a painting may well be a daub if you can't figure out which way to hang it. And if some beatnik welds together a collection of rusty cogwheels and old corset stays and claims it's a greater sculpture than Michelangelo's "David," let's have the courage to say that it looks like junk and probably is.

Let's blow the whistle on plays that would bring blushes to an American Legion stag party. Let's not be awed by movie characters with barnyard morals even if some of them have been photographed climbing

aboard the Presidential yacht. Let us pay more attention in our news columns to the do something for the good of others.

In short, gentlemen, let's cover up the cesspool and start planting some flowers.

Well, that's the jeremiad. I never thought I'd deliver one of these. I never dreamed I'd go around sounding like an advance man for the Watch-and-Ward society. I used to consider myself quite a liberal young man. I still think that on some people bikinis look fine.

But I am fed up to here with the educationists and pseudo-social scientists who have under-rated our potential as a people. I am fed up to here with the medicine men who try to pass off pretense for art and prurience for literature. I am tired of seeing America debased and low-rated in the eyes of foreigners. And I am genuinely disturbed that to idealistic youth in many countries the fraud of Communism appears synonymous with morality, while we, the chief repository of real freedom, are regarded as being in the last stages of decay.

We can learn a lesson from history. Twice before our British cousins appeared heading into a collapse of principle, and twice they drew themselves back. The British court reached an advanced stage of corruption under the Stuarts. But the people rebelled. And in the wild days of George IV and William IV it looked as though Britain were rotting out again. But the people banged through the reform laws, and under Victoria went on to the peak of their power.

In this hour of fear, confusion and self-doubt let this be the story of America. Unless I misread the signs a great number of our people are ready. Let there be a fresh breeze, a breeze of new honesty, new idealism, new integrity.

And there, gentlemen, is where you come in. You have typewriters, presses and a huge audience.

How about raising hell?



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK (R)

A STUDY OF THE EFFECT OF MODERATE BLOOD ALCOHOL LEVELS ON DRIVING AND DRIVING-RELATED FUNCTIONS

Conducted November 12, 1962

The experiment was designed for purposes of (1) research and (2) public education.

The following organizations, agencies, groups and individuals participated in the planning and/or execution of the experiment: Sioux Falls Safety Council, Sioux Falls Police Department, Sioux Falls Traffic Engineering Department, S. D. Highway Patrol, S. D. State Medical Association,* Washington Senior High School Driver Education Instructors, Municipal Judge Verne H. Jennings of Sioux Falls, Municipal Judge Merton B. Tice of Mitchell, County Judge William H. Heuermann of Sioux Falls, the South Dakota Auto Club, State Chemist D. J. Mitchell, and others.

Ten volunteer subjects, all 21 years of age or older, were recruited to take part in the tests. On the day of the experiment only eight were able to be on hand.

The five men and three women were given physical examinations, tests of eyesight, actual driving over a closed, off-street course and an Alcoholic Influence Report Form was completed on each. They were also administered a Breathalyzer examination.

The six (four men and two women) compiling the best scores on the driving examination were given measured amounts of various alcoholic beverages. Four of them drank for one hour and two for an hour and a half. The amounts were calculated by the chemist, Mr. Mitchell, to bring the blood alcohol levels to about .12 per cent which is well below 0.15 per cent, the figure presumptive of intoxication under South Dakota law.

Table 1 shows weight, sex, alcohol consumed, periodic Breathalyzer readings and blood alcohol percentages. Subjects 'D' and 'H' were given 90 minutes to complete their drinking. The others finished in 60 minutes.

Table 2 shows penalty points and time for the driving phase, stopping distance from 20 miles an hour, and average simple reaction time on the Porto-Clinic both before and after drinking. It also shows blood alcohol level and observers' opinions as to degree of intoxication.

Table 3 shows results of vision tests before and after drinking.

All subjects showed definite signs of impairment after drinking. All except 'H' received more penalty points after drinking than before. Four of them needed more time to complete the course after drinking. Subject 'B' completed the layout substantially faster but made far more errors. Both time and score for 'H' showed slight decreases; however, the tables do not show that he drove over a curb while turning the car around between events nor that the safety observer in the car had to use the dual brake to stop the vehicle on one occasion. The subject says he stopped the car on that occasion, and it is possible that both depressed their brake pedals. It is noteworthy that in the "sober" driving test Mr. 'H' had the highest number of penalty points and was fifth out of six in the time required to drive the course. On the other hand his reaction time and stopping distance before drinking were the best of the six. After drinking they were the poorest.

All subjects had poorer reaction times on the Porto-Clinic and four of them had greater stopping distances after drinking. Subjects 'D' and 'E' did not attain the desired speed of 20 mph at the time the brake detonator was fired during the after-drinking phase, so their stopping distances were shorter.

Prior to the drinking phase subjects admitted being nervous and tense. This was borne out by observation. As drinking progressed, this tension obviously disappeared.

During the post-drinking test of driving, subjects were more reckless, showed poorer control of acceleration and braking. They had more confidence in their ability but this confidence was not justified as shown in the results and observations. Their handling of the car was noticeably rougher.

None of the six subjects were in any condition to drive an automobile on the street or highway.

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* Representatives of The South Dakota State Medical Association were Doctors G. Malcolm Jameson and L. H. Mattice of Sioux Falls.

TABLE 1

Breathalyzer Reading

Time after completing last drink shown in ( )

Subject A — 157 pounds, male

6½ oz. 100 proof bourbon, soda, ice	(20 min.) .104%	(30 min.) .113%	(40 min.) .12%	(50 min.) .133%	(60 min.) .125%*	(129 min.) .116%

Blood alcohol percentage at time 61 minutes = .113%

Subject B — 110 pounds, female

4 oz. vodka, Collins mix, ice	(37 min.) .095%	(47 min.) .123%	(58 min.) .13%*	(136 min.) .114%	

Blood alcohol percentage at time 59 minutes = .127%

Subject D — 180 pounds, male

8 bottles 3.2 beer (tested 3.09% by weight)	(23 min.) .12%	(34 min.) .114%	(48 min.) .13%	(57 min.) .105%*	(129 min.) .093%

Blood alcohol percentage at time 64 minutes = .103%

Subject E — 153 pounds, male

7 oz. 100 proof bourbon, white soda, ice	(34 min.) .13%	(44 min.) .07%(?)	(53 min.) .128%*		(133 min.) .12%

Blood alcohol percentage at time 57 minutes = .108%

Subject G — 130 pounds, female

5½ oz. 100 proof bourbon, soda, ice	(31 min.) .137%	(41 min.) .15%	(55 min.) .123%*	(88 min.) .125%	(127 min.) .12%

Blood alcohol percentage at time 52 minutes = .136%

Subject H — 177 pounds, male

4 oz. 100 proof bourbon, water, ice 5 bottles high point beer (tested 3.71% alcohol by weight)	(20 min.) .145%	(32 min.)** .155%	(46 min.) .175%	(56 min.) .152%*	(126 min.) .11%

Blood alcohol percentage at time 57 minutes = .126**%

*Taken just prior to driving.

**Became sick. Vomiting unabsorbed alcohol from the stomach would be likely to affect breath test, making percentage higher than actual.

Subject 'A' said, after the effects of the drinking had worn off, "I wouldn't have been driving when I did had it been my own car." His blood alcohol level was 0.11 per cent.

Subject 'G' described her feelings as she began the test drive (after drinking) as: confident, happy, bold, and aggressive. "I was convinced that no alcoholic drinks should be consumed while driving," she said later.

Subject 'E', responding to questions several days after the experiment, had this to say: "I believe my driving was more automatic. At the time I felt I did quite well but am sure my reaction was slower even though I felt I was capable of handling any situation that may have presented itself." Subject 'E' was definitely impaired as shown by the various examinations, however.

Laboratory analysis of blood samples was made at the State Chemical Laboratory, Vermillion. Since the State Chemist was involved in the experiment and knew the Breathalyzer results, his assistant, Eldon Anderson, did the blood analysis. Only then did the two compare figures.

TABLE 2

	Driving Penalty Points	Course Time (Seconds)	Stopping Distance (Feet-Inches) (From 20 mph)	Blood Alcohol % Just Before Driving As Determined by Breathalyzer	As Determined by Blood Analysis	Visual Observation	Average Porto-Clinic Reaction Time
Subject A							
Before Drinking	72	111	40-7				.513
After Drinking	84	123	52-3	.125	.113	Obvious	.673
Subject B							
Before Drinking	94	215	42-7				.413
After Drinking	155	177	48-6	.130	.127	Obvious	.437
Subject D							
Before Drinking	54	102	42-7				.397
After Drinking	90	145	40-6 (speed less than 20 mph)	.105	.103	Slight	.420
Subject E							
Before Drinking	66	106	48-6				.453
After Drinking	75	129	44-5 (speed less than 20 mph)	.128	.108	Slight	.477
Subject G							
Before Drinking	38	110	40-11				.390
After Drinking	116	152	50-6	.123	.136	Obvious	.470
Subject H							
Before Drinking	101	131	38-6				.290
After Drinking	99	125	52-6	.152	.126	Very Obvious	.613

Table 4 shows a comparison between Breathalyzer results and blood analysis. The Breathalyzer was operated by Patrolman Louis Fratzke, South Dakota Highway Patrol, Pierre. Blood specimens were withdrawn by Dr. G. Malcolm Jameson, M.D. Analysis of the blood was made by Eldon W. Anderson, South Dakota State Chemical Laboratory, Vermillion.

Differences between Breathalyzer and blood results varied from plus .020 per cent to minus .013 per cent, with the exception of Subject 'H'. As mentioned in the footnote to Table 4, 'H' became ill after drinking and vomited several times.

It seems logical to assume that if a minimum waiting period of 20 minutes after drinking is necessary to get an accurate Breathalyzer reading, that a similar waiting period should be observed after vomiting, in order to insure accuracy. This was not considered at the time and there is no record of the length of time between illness and any one Breathalyzer test. However, he was first ill about 30 minutes after finishing the last drink.

As a part of the laboratory procedure, samples of beers from the same cartons used in the experiment were analyzed to determine alcoholic content. Results showed the "3.2" beer had 3.09 per cent alcohol by weight. The "high-point" beer measured 3.71 per cent.

One of the two principal purposes of this experiment was public education.

TABLE 3

	Visual Acuity	Depth Perception Sum of Three Porto-Clinic Trials (inches)	Phorias	Glare Recovery
Subject A				
Before Drinking	20/15	½		
After Drinking	20/15	1¾	Displaced but same in amplitude	+ 33%
Subject B				
Before Drinking	20/13	1½		
After Drinking	20/13	2	Reduced from 14 to 9	N. C.
Subject D				
Before Drinking	20/20	¾		
After Drinking	20/20	1¼	Reduced from 17 to 11	N. C.
Subject E				
Before Drinking	20/15	1¼		
After Drinking	20/20	1¾	Reduced from 12 to 8	N. C.
Subject G				
Before Drinking	20/20	½		
After Drinking	20/20	1	Reduced from 21 to 18	+ 33%
Subject H				
Before Drinking	20/10	½		
After Drinking	20/25	3¼	Reduced from 10 to 6	+ 50%

TABLE 4

Subject	Time after finishing last drink (min.)	Breathalyzer	Time after finishing last drink (min.)	Blood	Difference
A	60	.125%	61	.113%	+ .012
B	58	.130%	59	.127%	+ .003
D	57	.105%	64	.103%	+ .002
E	53	.128%	57	.108%	+ .020
G	55	.123%	52	.136%	- .013
H*	56	.152%	57	.126%	+ .026*

* Became sick and vomited periodically during the period from 32 minutes after last drink to 126 minutes after last drink. This, it is presumed, would act to make Breathalyzer readings higher than would otherwise have been observed.

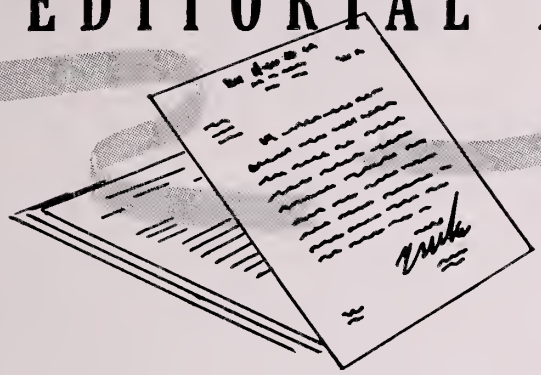
Both the Associated Press and United Press International filed stories reporting the immediate results of the experiment. One or the other of these reports was carried by the following newspapers: Sioux Falls Argus-Leader, Sioux City Journal, Aberdeen American-News, Huron Daily Plainsman, Watertown Public Opinion, Mitchell Daily Republic, Pierre State News, Pierre Capital Journal, Yankton Press and Dakotan.

A news release summarizing the results was sent to all weekly newspapers in South Dakota. Information on the extent of its use is not yet available.

Television stations KSOO-TV and KELO-TV took extensive movies of the project and their films have been edited for use on the air. In addition both stations have offered their films to the Safety Council for subsequent showing to meetings and gatherings.

SIOUX FALLS SAFETY COUNCIL
December 13, 1962

EDITORIAL PAGE



BLUE SHIELD — OUR OPPORTUNITY

One of the little-known virtues of Blue Shield is that it offers each individual physician an opportunity to do something specific about the future of medical care in America. Blue Shield challenges every one of us to back up our convictions and to strike a solid blow for medical freedom.

More than 150,000 of us have voluntarily enrolled with our local Blue Shield Plans as "participating physicians." But how many of us truly **participate?** And how many of us really appreciate the crucial importance of "participation" — of all-out, enthusiastic support for our Blue Shield program?

For Blue Shield is not — cannot be — a "spectator sport" for the American physician. On the contrary, Blue Shield is a physician-participation show, or it's no show at all!

What, then, are the specific ingredients of **participation?** What does Blue Shield challenge us to do for medicine? Our first duty is to become informed — to know our own Blue Shield program, to understand its problems, its objectives and its specific policies. Secondly, we are challenged to identify ourselves with Blue Shield, and Blue Shield with ourselves. For Blue Shield is not a "third party" — it's us. We should speak — early and often — about Blue Shield to our patients and friends. We should let the public know what a tremendous social asset it has in Blue Shield, and what a great instrument it can be for the provision of an ever broader program of medical care prepayment by voluntary effort.

Perhaps most important of all, true **participation** in Blue Shield means **performance.** It means that we accept unequivocally the responsibility of assuring that Blue Shield provides benefits to whatever extent the subscriber's contract and our own agreement as a participating physician commits us. It means that we make Blue Shield a symbol not only of protection against economic catastrophe, but of the assurance of the highest quality of medical care for every American.

WHAT IS AMWA?

If you are interested in medical writing, in educational processes, in editing, publishing, or any other aspects of medical communication — then you may profit by becoming a member of the American Medical Writers' Association.

AMWA, now 20 years old, is a national professional society of people who are engaged or interested in medical communications. It stages an annual 2-day convention (Chicago in '63; Philadelphia in '64); provides a medical manuscript editing service and a national placement service for members; grants awards and certificates for outstanding accomplishments in medical writing and editing; judges medical writing contests, maintains a roster of lecturers on medical writing, and offers scholarships for people contemplating a career in this field.

AMWA publishes a monthly **Bulletin** as well as pamphlets on various aspects of medical writing. Chapters of AMWA are active in the metropolitan New York, Chicago, Philadelphia, Washington, Detroit and San Francisco areas.

AMWA membership embraces editors and publishers in the field of medicine, dentistry, nursing and allied professional groups; writers and editors associated with hospitals, pharmaceutical companies, foundations, publishing houses and advertising agencies — and many physicians who are interested in problems of medical communications, or who just want to write more effectively. Dues are $10.00 a year. AMWA's national office is at 250 West 57th Street, New York 19, New York.

LETTERS TO THE EDITOR

Dec. 27, 1962

John C. Foster, Exec. Secy.
SDSMA
S. D. Journal

Dear John:

My rocking chair I seldom use,
But I often sit and muse
About my comments. Some are rough,
But I am writing all my stuff
From observations, and as such
May not amount to very much.
But sure as wagons must have wheels,
It's often the stuck pig that squeals.

Sincerely,

L. J. Pankow, M.D.

January 4, 1963

TO THE EDITOR:

An excellent opportunity exists for a young American general practitioner with an interest in surgery, to work with the famed Burma Surgeon, Dr. Gordon S. Seagrave, at his 250-bed hospital in Namkham, Burma.

Minimum appointment is for two years. With satisfaction an extended tenure would be encouraged.

The candidate should be an American citizen of any race or religion but his age should not exceed forty. He may be married or single. If married to a trained nurse, there would be an important place for her in the nurses training program; or to a school teacher, an opportunity to teach in the secondary school on the hospital compound.

Extensive experience is not a requirement but graduation from an "A" class medical school is. Professional practice at the Namkham Hospital is intensive, widely varied and often rare to Western medical experience.

The candidate must be prepared to leave for Burma not later than the Spring of 1963, or sooner if possible (depending upon issuance of his visa) so that his appointment can overlap that of the American doctor now serving the program.

This appointment offers a modest salary per annum. Travel expenses and Western style housing will be provided.

Anyone interested should please write: American Medical Center for Burma, Inc., 6 Penn Center Plaza, Philadelphia 3, Penn. stating qualifications, etc.

Sincerely yours,
John F. Rich
Executive Vice Chairman

MATERNAL MORTALITY IN SOUTH DAKOTA

During the past decade the South Dakota Maternal Mortality Committee has studied all maternal deaths in the state. A number of these have educational value for all doctors who practice obstetrics, or who see obstetric patients in consultations. Therefore, some of these are being presented in your State Medical Journal in summarized form with brief discussion. In most instances these are composite reports, borrowing features from several cases. As in all maternal mortality studies, specific identification has been avoided.

Maternal Mortality Committee of the South Dakota Society of Obstetrics and Gynecology

MATERNAL DEATHS FROM POSTPARTUM HEMORRHAGE

1. Gravida XII, Para X, Abortion I, age 39. No prenatal care. The patient had a long-standing history of tuberculosis and bronchitis. Apparently she was in her sixth month of gestation, and had had cramps and slight bleeding for four days prior to seeking medical care. The cervix was nearly completely dilated when she entered the hospital. The patient was taken to the delivery room, scrubbed, and within minutes a breech delivery was performed.

Almost immediately there was heavy third-stage bleeding. Intravenous fluids had been started, but the patient thrashed around, pulling the needle out of the vein. The Obstetrician tried to control bleeding with bimanual, intravaginal and abdominal massage and compression of the uterus. Another physician made a cut-down in an arm vein. No blood bank was available in the community.

Bleeding continued. An unsuccessful attempt was made to remove the placenta manually. The patient expired within 1 hour and 35 minutes after delivery.

A post mortem attempt at manual removal of the placenta was also unsuccessful because portions of the placenta seemed to be "densely adherent to the uterine wall." No autopsy was obtained.

COMMENT

The committee could understand the severity of this emergency. There were, however, several items lacking from the report which were questioned by committee members. No note was made concerning the use of intravenous ergotrate, or other oxytocic agent to contract myometrium. Likewise, no mention was made of the location of the placenta. With the antepartum and intrapartum spotting, and breech presentation, one would consider the probability that this patient had a placenta previa. Placentas of this location separate poorly (because of insufficient underlying decidua) and are more likely to show some tendency to placenta accreta. The use

of bimanual massage and compression was a good emergency measure.

After much discussion, the committee voted this a probably preventable maternal death had there been a blood bank available, and had a rapid, emergency abdominal hysterectomy been performed.

2. Gravida III, Para II. Age 45. The patient had an old history of peptic ulcer (3 operations). Likewise, she had had two extensive episodes of hematuria and flank pain during the preceding year. Blood pressure was 190/120. The patient was anemic, and there was a trace of albumin in her urine. She had bouts of nocturnal angina and dyspnea. Her weight was well-controlled.

For the above reasons the patient was admitted to the hospital about 10 days prior to her expected term date. Three days later she started labor spontaneously. After 12 hours of labor the patient's cervix was about 5 cm. dilated, the station of the fetal head was about -2. The attending physician consulted by telephone with another physician, who advised amniotomy. This was done.

Previous babies had weighed 7 lb. 9 oz., and 6 lb. 8 oz. This fetus was estimated to weigh 6 lb. 5 oz. After 19 hours of labor the attending physician judged the patient's general condition to be worsening; her pulse was 126 per minute. The patient was, therefore, placed on the delivery table and scrubbed. Cervical incisions were made at 10 and 2 o'clock. The fetal head was manually rotated from OLP to OLA. "High-mid-forceps" were applied and the baby was delivered and resuscitated. This operative procedure was performed while the patient received ether and oxygen. The placenta was removed manually. Intramuscular ergotrate was given.

The patient had many varices and "episiotomy bleeding" was noted to be excessive. After episiotomy repair some bleeding continued, though this was apparently not extremely heavy, for the patient was returned to her bed and no note was made of the pulse or blood pressure during this interval.

Two hours after delivery the patient developed shock, and was given transfusion and oxygen, but died about 4 hours postpartum. No autopsy was obtained.

COMMENT

The committee noted several areas of information which were not available in the report. No note was made concerning the effectiveness of uterine contractions; this labor is rather characteristic of inertia, common to elderly multipara. A note that the cervix was "not completely" effaced caused the committee to discuss the possibility of constriction ring dystocia at the junction of the lower and upper segments of the uterus — a rare cause for high fetal heads and inertia. Apparently this was not present at the time of delivery for forceps were applied to the fetal head. The committee agreed that if uncomplicated uterine inertia were causing the prolonged labor, a dilute (3 minims to 1000 cc.) pitocin solution, intravenously, slowly, should have stimulated effective contractions and resulted in a less traumatic, spontaneous delivery.

No note was made concerning examination for uterine or vaginal extensions of the Duhrssen's incisions of the cervix, nor was note made concerning cervical repair. Characteristically, postpartum hemorrhage is dangerous, because though often not excessive in amount, it is steady, and much of it is hidden in the dilated uterus, cervix, and vagina, which can easily hold a quart or more before external bleeding is remarkable. One attendant may massage the uterus, expel clots, and go about her business. Ten minutes later another attendant may massage the uterus and expel clots; thus, with poor communication, much blood may be lost. Superimposed on these sources of error is another danger inherent in the physiology of pregnancy. Because of hemodilution and increased blood volume of pregnancy, a pregnant or postpartum woman will go along with a nearly normal pulse and blood pressure, while steadily losing heavy quantities of blood, until finally her adaptive mechanisms of vaso-constriction will no longer respond; at this critical point her pulse will ascend rapidly and the blood pressure will almost disappear. This sudden shock, while not irreversible, is more dangerous in the pregnant or postpartum patient because she is much farther along the road than would be her non-pregnant sister in shock. Therefore, all precautions should be taken to avoid continuing blood loss postpartum, and to treat hemorrhage actively and early, before this shocky state develops. Inspection and repair of the uterus, cervix, vagina, and vulva were

indicated immediately after delivery in this patient. If bleeding persisted, abdominal hysterectomy may have been indicated. The committee voted this a preventable maternal death.

3. Gravida IV, Para IV. Age 42. This patient had eclampsia in association with her second pregnancy. Her blood pressure during this pregnancy reached 160/90. She was delivered spontaneously at term. The placenta was delivered in 3 minutes by means of a "Crede" maneuver. The report indicated that there were no cervical or vaginal lacerations. Third-stage bleeding was recorded as "normal," but bleeding during the first 24 hours was recorded as a "little more" than normal. The placenta was routinely inspected at delivery.

For some reason the attending physician felt constrained to visit the patient at home each day, after she left the hospital on the 9th postpartum day. On the 14th postpartum day the patient suddenly started to have bright red bleeding. She was immediately returned to the hospital. Her blood pressure was 90/60. Her pulse was weak and rapid. However, vaginal bleeding was "nearly stopped." The uterus was barely palpable abdominally. Vaginal exam was not performed at this time.

A consultant was called by telephone. He recommended transfusion and curettage. Curettage was done 2½ hours after admission. B.P. was 120/80 and pulse was 100. A moderate amount of placental tissue was obtained. 1000 cc. whole blood was started 6 hours after admission and was completed in 2 hours. 9 hours after admission profuse bleeding was noted. The patient's pulse became thready, her blood pressure disappeared; she exsanguinated and died in 45 minutes. No autopsy was obtained.

COMMENT

The committee discussed the use of "Crede" maneuver. This squeezing is traumatic to the myometrium, and interferes with the physiologic contractions which normally shear off the placenta from its implantation.

The recording of a "little more" than normal bleeding during the first 24 hours may have made the attending physician suspicious that all placental tissue was not out of the uterus. He was certainly careful to keep this patient in the hospital 9 days, and to observe her each day thereafter.

Typically, delayed postpartum hemorrhage from retained placental tissue will occur when fragments of tissue start to separate and the uterus tries to squeeze out the "foreign body." This usually occurs within 3 weeks. In this instance, it occurred in 2 weeks.

No mention was made of a blood count or hematocrit during the 9 hours of the second admission. Whether the second hemorrhage was due to (1) incomplete emptying of the uterus at curettage, (2) hypofibrinogenemia, or (3) partial rupture of the uterus at curettage, cannot be decided because no autopsy was performed, and no blood studies are available. The patient only received 1000 cc. of blood. No doubt, her condition warranted the use of more blood if it was available. The committee voted this a preventable death.

GENERAL COMMENT

Postpartum hemorrhage (including third-stage hemorrhage) may be divided into **Immediate** and **Delayed** hemorrhage.

Immediate hemorrhage, starting within the first hour or two after delivery, may be caused by (1) **retained placenta** or placenta accreta, (2) **rupture** of the uterus, cervix, vagina, or perineum, (3) uterine **inertia,** due to multiple pregnancy, large babies, hydramnios, fatigue, spinal or general anesthesia (especially ether), or simply faulty contractions, (4) **hypofibrinogenemia,** and (5) **Inversion** of the uterus.

Treatment includes: (1) Evaluate the birth canal from the top, down, for retained tissue or laceration (remove or repair), (2) bimanual massage and compression as an emergency control of hemorrhage, (3) crossmatch and replace all the lost blood as fast as possible, (4) oxygen for the mother, (5) evaluate and correct blood clotting deficiencies, and (6) when bleeding from a uterus cannot be controlled, rapidly remove the offending organ before the patient reaches irreversible shock.

Delayed postpartum hemorrhage, noted any time after one or two hours postpartum, may be caused by (1) vulvar or vaginal hematoma, and (2) most of the above listed causes. As soon as a hematoma is discovered it should be opened, drained, bleeders ligated and sutured closed. If bleeders cannot be located,

(Continued on Page 38)



The continued achievement of high standards of patient care in the preventive, curative, and restorative aspects of illness depends upon a harmonious, collaborative relationship between medicine and nursing. In an effort to protect and foster an enduring alliance of understanding and cooperation between these 2 major health professions, the Committee on Nursing has instituted a continuing program of liaison, communication, education, and research. The Committee has authorized publication of the following report on its objectives and program.

VERONICA L. CONLEY, PH.D., *Secretary*

Objectives and Program of the AMA Committee on Nursing

The program of the AMA Committee on Nursing is based on 3 general assumptions: (1) that nurses have a separate and distinct professional status and their contributions are those of co-workers; (2) that nursing should expect the medical profession to support and endorse high standards of nursing education and service; and (3) that each of the various levels of academic and technical accomplishment in nursing makes its own unique contribution to the total health care of the public.

On the basis of these broad assumptions, the Committee has adopted the following objectives:

1. To expand and strengthen liaison activities between organizations representing the medical and nursing professions at the national, state, and local levels.

Liaison has been established with all the major nursing organizations (including the American Nurses' Association, the National League for Nursing, the National Federation of Licensed Practical Nurses, the National Association for Practical Nurse Education and Service, and others) as well as with constituent and component medical associations, medical specialty groups, and several national organizations with a collateral interest in nursing.

The Committee feels that one of its major contributions is to promote interprofessional conferences between physicians and nurses. A committee composed of AMA and ANA representatives is now planning a conference on nurse-physician aspects of professional practice. The Committee on Nursing will also encourage the inclusion of nurses on programs of national and state medical meetings and attempt to remedy the scarcity of positively oriented, unbiased material on nursing in the medical literature.

2. To study and report to the medical profession on current practices and trends in nursing and on developments among nursing auxiliary personnel.

Through its headquarters staff, the Committee is collecting information on nursing matters vital to physicians. A file of abstracts, excerpts, and reprints is available for quick reference.

3. To stimulate, initiate, and, where feasible, support research in areas pertinent to the nurse-physician relationship in professional practice.

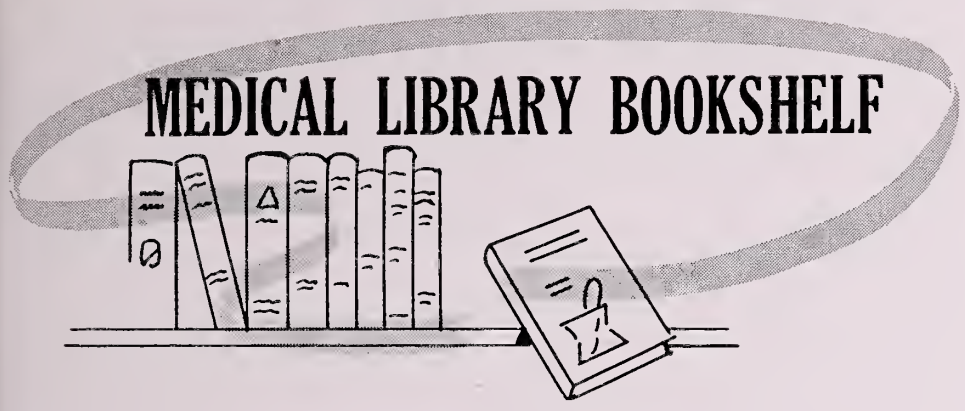
Such research requires the collaboration of many disciplines. Several nurse-physician teams are now engaged in extensive research projects. These include studies of inter-disciplinary participation in planning care; the nursing needs of chronically ill ambulatory patients; and the amount and type of nursing service which makes the maximum contribution to maternal and infant welfare.

4. To offer advisory services to both professions on interprofessional matters.

The secretary and chairman of the Committee serve at present on the committee on careers of the National League for Nursing. The secretary is also a member of the advisory council of the National Federation of Licensed Practical Nurses, the National League for Nursing's committee to study costs of nursing education, and the hospital advisory council of the National Association for Practical Nurse Education and Service. The Committee will also serve as a consultant group to committees, councils, and departments within the AMA. Similar services have been offered to constituent and component medical associations.

5. To provide support and assistance to the nursing profession and its nonprofessional auxil-

(Continued on Page 38)



SOME RECENT TEXTBOOKS

Medical librarians must be on the alert for the publishing of new editions of the numerous textbooks that are the "backbone" of the medical collection in a medical school library. There is no single source that lists the new editions of textbooks published during a specific year.

The following are some of the important textbooks that would be of interest to those in the clinical as well as the teaching field:

Anatomy in Surgery by Philip Thorek, Clinical Professor of Surgery, University of Illinois, 2nd ed., Lippincott, 1962.

Added to this new edition is the anatomic application to the newer cardiovascular surgery and to some surgery involving such organs as the liver.

The procedures which are presented stress mainly the surgical anatomy as it is applied to the given procedure. The most common anatomic arrangements have been included, as well as the more common anomalies, particularly those having some clinical bearing. The book is intended to bridge the gap which exists between freshman anatomy and operative surgery by a simple method of presentation and correlation. One outstanding feature is the original drawings by Carl Linden, many presented in third dimensional views and all closely analogous to the text.

Gynecology and Obstetrics by John William Huffman, Professor of Obstetrics and Gynecology, Northwestern University Medical School. Saunders, 1962.

This first edition of 1190 pages is dedicated, according to the author to "that always delightful but sometimes enigmatic biological phenomenon: the Human Female." According to the preface, this book is designed to give the student a summation of accepted present-day concepts in gynecology and obstetrics with the arrangement of the chapters in accordance with the growth and regression of the genitalia. This permits the reader to integrate the age of the human female from conception to senescence with the steps in the development of her genitalia; the physiologic processes, which they manifest, and the morbid conditions which affect them. Treatment is described, but the emphasis, for the most part, is placed on the principles which guide gynecologic and obstetric management.

Textbook of Endocrinology edited by Robert H. Williams, Professor of Medicine, University of Washington Medical School. Saunders, 1962. Contributions by twenty-one well known authorities. The tremendous progress in endocrinology and metabolism during recent years necessitated three editions of this textbook since 1950. More than 70 per cent of this edition has been written by new authors and most of the rest has been rewritten so it is essentially a new book. Excellent chapters on general principles of the physiology of the endocrines: the Thyroid; Adrenals; Testes; Ovaries; Pancreas; Neuroendocrinology and others. Physiologic and pathologic considerations, diseases, clinical laboratory tests, chemistry, therapy, manifestations and diagnosis are included. Up to date references are at ends of chapters.

Todd-Sanford Clinical Diagnosis by Laboratory Methods edited by I. Davidsohn and

B. B. Wells with numerous contributors. 13th ed., Saunders, 1962. The first edition published in 1908 had 319 pages and measured 7½ x 5 and was authored by Dr. James C. Todd, Associate Professor of Pathology at the University of Denver from a set of notes which the author dictated to his classes. Dr. Todd died in 1928 and the 7th edition published in 1931 had for its author Dr. A. H. Sanford. Dr. B. B. Wells became co-author of the 12th edition and when Dr. Sanford died in 1959 Dr. I. Davidsohn, Chairman of the Dept. of Pathology of the Chicago Medical School and Dr. Wells, Dean of the California College of Medicine became co-authors. The present edition has 1,020 pages and measures 10 x 7 inches, quite a contrast to the 1st edition. This 13th edition has many changes from the former edition. The fields of hematology, microbiology, and clinical chemistry have been greatly expanded and each now appears as a separate chapter. In addition to the basic chapters on blood there are separate chapters on blood groups and on the hemorrhagic disorders. Immunohematology is included as a key to understanding many old pathogenetic puzzles; as a practical diagnostic tool, and as a guide to therapy. Microbiology is dealt with in seven chapters, including one on microbiologic methods. A chapter on clinical chemistry gives fundamental principles and basic techniques with special phases in 5 new chapters: Water and electrolytes; Microbiochemical techniques in pediatrics; Tests of hepatic function; Serum enzyme determinations; and Laboratory tests aiding in the diagnosis of pancreatic disorders. Topics appearing for the first time are chapters on statistical tools in Clinical Pathology, Isotopathology, Hospital epidemiology, and a brief discussion of space and equipment needs in the modern clinical laboratory. Classic and traditional subject matter that have current validity or can be used in the teaching process have been retained.

Esther Howard

Medical Librarian

MATERNAL MORTALITY—

(Continued from Page 35)

a tight pack must be inserted, to be removed slowly during the next 48 hours.

Retained placental tissue causing delayed postpartum hemorrhage should be carefully, but thoroughly curetted out of the uterus. Intravenous ergotrate given just before curettage may cause the myometrium to contract enough so that curettage is made safer and easier, with less likelihood of perforation. The manipulation of old placental tissue often causes hypofibrinogenemia; therefore, clotting time, clot retraction, and fibrinogen levels may need to be watched. If the fibrinogen level drops, fibrinogen should be replaced.

Generally it is true with obstetric bleeding that one need not replace the first 300 to 500 cc. of blood loss. Where blood loss exceeds this amount, all lost blood should be accurately estimated and promptly replaced.

MEDICAL ECONOMICS—

(Continued from Page 36)

iary personnel in their efforts to maintain high standards.

Nursing, like medicine, is faced with pressing demands for change if high standards are to be maintained in our present environment of rapid scientific and social advances. Nursing is now engaged in a continuous reevaluation of its educational system, its scope of services, its legal responsibilities, and other phases of its practice which reflect in the quality of patient care. This Committee supports the efforts of the nursing profession in maintaining high standards and offers its cooperation and assistance.

6. To encourage physicians to accept invitations to serve on nursing school faculties.

In view of growing pressures on the professional nurse to assume responsibilities of a medical nature, the teaching role of the physician warrants reevaluation. At the present time, some nursing schools are finding it necessary to assign nurse faculty members to lecture on medical subjects.

If the medical and nursing professions are to make the fullest use of their joint potential, they must have not only a common denominator of interest in the patient and a comparable body of knowledge, but also the kind of relationship that derives from a deeper appreciation of, and respect for, each other as allies working toward the same goals.

Clarence H. Benage, M.D.
Elias S. Faison, M.D.
Benson W. Harer, M.D.
Charles L. Leedham, M.D.
William R. Willard, M.D.
Arthur A. Kirchner, M.D., Chairman

Reprinted From The Journal of The American Medical Association, August 4, 1962, Vol. 181, Page 430
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COUNCIL MEETING
SUNDAY, JANUARY 13, 1963
SHERATON CATARACT HOTEL
SIOUX FALLS, SOUTH DAKOTA

The meeting was called to order at 1:00 P.M. by Chairman E. P. Sweet, M.D. Present for roll call were Drs. Magni Davidson, R. H. Hayes, A. P. Reding, C. J. McDonald, E. J. Perry, J. J. Stransky, M. C. Tank, Paul Hohm, P. P. Brogdon, E. T. Lietzke, T. H. Sattler, J. T. Elston, E. P. Sweet, H. E. Lowe, and E. A. Johnson.

The Executive Secretary read the minutes of the previous meeting. Dr. Brogdon moved that the minutes be accepted as read. The motion was seconded by Dr. Stransky and carried.

Each Councilor then reported on the opinion of his District concerning a revision of the Bylaws to change the method of appointing the Nominating Committee at the annual meeting. Dr. Hohm moved that the Bylaws not be changed but that recommendations for nominations to the Nominating Committee be forwarded to the President, by the District Societies, sixty days prior to the annual meeting. The motion was seconded by Dr. Stransky and carried.

Mr. Foster reported on the survey conducted by the executive office on the Group Loss of Time insurance coverage, and discussed the situation for the information of the Councilors. Dr. Perry moved that the State Association continue its endorsement of the Harold Diers program for a period of one year. The motion was seconded by Dr. Stransky. A discussion followed and Dr. Sattler moved to amend the motion to the effect that the Council also recommends endorsement of the group loss of time program presented by the Combined Casualty Company, allowing the members to make a choice. The amendment to the motion was seconded by Dr. Tank and the motion, as amended, was carried.

The Executive Secretary reported that a report from the Medical Legal Committee had not been received concerning the establishment of a Review Board with the attorneys in the State. The Council instructed Mr. Foster to re-contact the committee and secure a report for the June meeting of the Council.

The recommendations to the Council by the Committee on Legislation were read as follows:

THE COMMITTEE ON LEGISLATION RECOMMENDS THE FOLLOWING TO THE COUNCIL AS THE STATE LEGISLATIVE PROGRAM FOR 1963:

1. Endorsement of the recommendation of the Committee on Tuberculosis with the exception of item #1 of those recommendations, calling attention to the fact that such enactment would establish a precedent in that it would make all TB patients wards and responsibilities of the State, irrespective of their ability to finance their own care.
2. Implementation of Medical Aid to the Aged under Kerr-Mills legislation on an insurance basis.
3. Revision of the Medical Corporation law to exempt such corporations from the business corporation act that limits a contract for services to a period of two years.
4. Place the O.A.A. program on an insurance basis through Blue Cross and Blue Shield.

THE COMMITTEE FURTHER RECOMMENDS ENDORSEMENT OF THE FOLLOWING IF THEY ARE INTRODUCED TO THE SESSION:

1. Iowa type of legislation on willing of portions of a person's body to eye banks, etc.
2. Wisconsin type of legislation on who may order an autopsy.
3. Unlimited medical and hospital benefits under Workman's Compensation.
4. Lien law for medical and hospital bills in personal injury cases.
5. Increasing fees for medical member of mental health board for attendance at mental illness hearings.
6. Inclusion of R.N.'s in the Good Samaritan Law.
7. Making the statute of limitation for liability the same for R.N.'s as for physicians.
8. Relieving R.N.'s from liability in Civil Defense activities.

Dr. Hayes moved that the Council endorse the recommendations of the Committee concerning the Tuberculosis control program, but questioning the inclusion of all persons regardless of the ability to pay. The motion was seconded by Dr. McDonald and carried.

A discussion of the implementation of the Kerr-Mills law in South Dakota followed. Dr. Tank moved that the Council accept the recommendation of the Committee on Legislation concerning the M.A.A. program. The motion was seconded by Dr. Elston and carried.

Mr. Foster discussed the amendments proposed for the Medical Corporations Act. Dr. Sattler moved that the Medical Association representatives at the legislative session follow the final recommendations of the Association's legal advisors regarding this particular bill and that the Council further accept the recommendations of the Committee on Legislation on the matter of removal of the time limitation on contracts for personal services. The motion was seconded by Dr. Tank and carried.

A discussion on the fees to be negotiated in the M.A.A. program was held. A letter from the 7th District Medical Society regarding this matter was read. Dr. Hohm moved that the Medical Association negotiate for a dollar coefficient on the Relative Value Scale of no less than $3.50 per unit value, and higher if possible, with the Welfare Department, for the operation of the M.A.A. program. The motion was seconded by Dr. Davidson and carried.

Dr. Tank moved that the recommendation of the Committee on Legislation regarding the endorsement of legislation concerning the willing of portions of the human body to eye banks, etc., be accepted. The motion was seconded and carried.

Dr. Elston moved that the Association endorse no change in the present law concerning autopsies at this time. The motion was seconded by Dr. Stransky and carried.

Dr. Brogdon moved that the Council reiterate its previous statement endorsing unlimited hospital and medical benefits in Workmen's Compensation cases. The motion was seconded by Dr. Hayes and carried.

Dr. Stransky moved that the Council accept the recommendation of the Committee on Legislation concerning a hospital and medical lien law in personal injury cases. The motion was seconded by Dr. Tank and carried.

Dr. Stransky moved that the Council accept the recommendation of the Committee on Legislation concerning legislation to increase the fee of the medical member of a mental health board for attendance at mental illness hearings. The motion was seconded by Dr. Hayes and carried.

The Council then considered the three bills presented by the Nurses Association for endorsement. Dr. Davidson moved that the Council accept the recommendations of the Committee on Legislation concerning these three bills. The motion was seconded by Dr. Perry and carried.

Mr. Foster discussed the O.A.A. program and indicated that no legislative change would be necessary to put the program on an insurance basis as

recommended, but it would become a matter of negotiation with the Welfare Commission.

The Council then considered legislation concerning a radiation laboratory for detection purposes. Dr. Sattler moved that the Medical Association support the recommendations of Dr. Van Heuvelen regarding the Radiation laboratory facilities. The motion was seconded by Dr. Brogdon and carried.

Dr. Paul McCleave, Director of the American Medical Association's Department of Medicine and Religion, spoke to the Council on the purposes and plans of this new Department. He asked that the State Medical Association authorize the appointment of a State Committee on Medicine and Religion. The Committee would meet to discuss areas of mutual concern and the type of program that might be carried out in South Dakota. The State Committee would encourage the District Medical Societies to carry out activities in this area. Dr. Brogdon moved that the Council authorize the president to appoint such a Special Committee. The motion was seconded by Dr. Hayes and carried.

A dispute between a physician and a hospital staff was discussed at length. A motion was made and adopted to inform the physician of avenues of action open to him.

Dr. Tank moved that Dr. L. L. Parke of Canton, South Dakota, be voted a Life Member of the Association, on the recommendation of the Seventh District Medical Society. The motion was seconded by Dr. Lietzke and carried.

A recommendation of the Budget and Audit Committee was introduced to the effect that annual sessions of the Legislature would affect future budgets. Dr. Stransky moved that when the present schedule of physicians attending the session has been completed, the second room in Pierre be released. He further moved that at future sessions, the Association maintain only one room, and that the number of physicians attending the sessions be limited to six or seven new physicians each session who would be present for no more than a total of two weeks per session. Provision could be made for special occasions when it would be necessary to call in physicians for special assistance. The motion was seconded by Dr. Brogdon and carried.

Information on the Self-Employed Individual Tax Retirement Act was distributed to the Councilors to be studied. Dr. Hohm moved that this matter be brought up for discussion at the June Council meeting. The motion was seconded by Dr. Brogdon and carried.

Dr. Stransky moved that Dr. R. H. Hayes be appointed as a liaison officer between the State Medical Association and the Office of the Surgeon General, Department of the Air Force. The motion was seconded by Dr. Sattler and carried.

The proposed budget for the 1963-64 fiscal year was read and discussed.

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
PROPOSED BUDGET 1963-1964

INCOME

State Dues	$40,000.00
Annual Meeting	6,300.00
Interest	200.00
Miscellaneous	1,045.00
Salary Reimbursement	100.00
Car Reimbursement	690.00
	$48,835.00

EXPENSES	(Proposed)	(Previous Year)
Salary, Executive Sec.	$ 7,500.00	$ 7,500.00
Salary, Other	7,125.00	9,000.00
Social Security	420.00	450.00
Legal & Audit	600.00	600.00
Telephone & Telegraph	1,500.00	1,200.00
Office Sup. & Equip.	3,000.00	3,000.00
Dues & Subscriptions	1,200.00	1,300.00
Officers Travel	2,200.00	2,500.00
Annual Meeting	5,000.00	500.00
Public Relations	4,000.00	4,500.00
Rent	2,400.00	2,400.00
Unemployment Taxes	40.00	40.00
Postage	1,600.00	1,200.00
Legislative Expense	1,850.00	3,000.00
Benevolent Fund	400.00	400.00
Med. School Endowment	200.00	200.00
Ladies Auxiliary	1,000.00	600.00
Refunds	200.00	300.00
Car Expenses	860.00	860.00
Staff Travel	4,500.00	5,000.00
Clinical Pathology	1,000.00	1,000.00
Miscellaneous	500.00	——
Reserve	1,000.00	1,500.00
Balance to Surplus	740.00	640.00
	$48,835.00	$47,690.00

JOURNAL—INCOME

Advertising	$24,000.00
Subscriptions	1,200.00
Miscellaneous	750.00
Refunds	100.00
	$26,050.00

JOURNAL EXPENSES

	(Proposed)	(Previous Year)
Salary, Bus. Manager	$ 3,600.00	$ 3,600.00
Salary, Editors	1,440.00	1,440.00
Salary, Staff	350.00	3,200.00
Social Security	13.00	104.00
Legal & Audit	50.00	100.00
Rent	900.00	1,800.00
Telephone & Telegraph	175.00	175.00
Office Supplies	17,842.00	24,000.00
Taxes	30.00	30.00
Unemployment Taxes	——	20.00
Postage	250.00	250.00
Travel Expense	——	750.00
Balance to Surplus	——	631.00
Due Midwest-Beach from 62-63	1,400.00	
	$26,050.00	$36,100.00

GROUP LIFE INSURANCE INCOME

Premiums	$30,000.00

EXPENSES

Payments to Ins. Co.	$29,100.00
Postage	50.00
Legal & Audit	50.00
Supplies	50.00
Balance to Surplus	750.00
	$30,000.00

BUILDING FUND INCOME

Blue Shield Rent	$ 4,800.00
Association Rent	2,400.00
Journal Rent	900.00
Board of Examiners Rent	300.00
Nurses Association Rent	900.00
OAA Rent	2,250.00
	$11,550.00

EXPENSES

Janitor & Repair	$ 1,400.00
Utilities	1,600.00
Interest	2,600.00
Repayment of Loans	3,450.00
Taxes & Insurance	2,000.00
Legal & Audit	500.00
	$11,550.00

Dr. Reding moved that the Council accept the budget as proposed. The motion was seconded by Dr. Hayes and carried.

The report of the Medical School Affairs Committee was read.
To the Council:

The Committee on Medical School Affairs recommends that the scholarships of $100 each to a freshman and a sophomore student be approved as in the past. Also that the scholarship for an entering freshman in the amount of $350.00 and $100.00 travel expense for an SAMA delegate be approved.

Considerable concern is felt by this committee about the salary level of the faculty members of the medical school and we feel that this should bear no relationship to salary schedules in the other schools within the State. The South Dakota School of Medicine offers one of the lowest salary schedules of any school in the country and the proposed increase, deducting the 5% set aside for retirement, leaves only 2% increase for the next year. It is likely that we will not only lose some of our present professorial staff but will have great difficulty in securing replacements.

This committee suggests for your consideration a recommendation to President Weeks that AMEF funds might well be used to augment faculty salaries at the University of South Dakota School of Medicine. This is money contributed by the doctors in the State and would seem to us to be a logical use of these funds.

Dean Walter Hard is setting up a Planning Committee regarding the future growth of the Medical School, and requests that two members be appointed by the President of the State Medical Association.

Respectfully yours,
Medical School Affairs Committee

Dr. Davidson moved that the State Association provide two $100.00 scholarships for a freshman and sophomore student; a $350.00 scholarship for an entering freshman; and provide $100.00 travel expenses for a delegate to the Student American Medical Association meeting in Chicago. The scholarships are to be awarded to native South Dakota students. The motion was seconded by Dr. Reding and carried.

Dr. Sattler moved that a letter be directed to President Weeks of the University of South Dakota indicating that the State Medical Association recommends the use of AMEF funds to augment salaries of faculty on the medical school staff. The motion was seconded by Dr. Stransky and carried.

Dr. Sattler moved that the Council authorize the President of the State Medical Association to appoint two members to the Planning Committee suggested by Dean Walter Hard. The motion was seconded by Dr. Brogdon and carried.

Dr. Sattler moved that the Council recommend that an appeal be made to the Governor and the legislature to provide funds for additional salary appropriations for faculty at the medical school. The motion was seconded by Dr. Hayes and carried.

Mr. Foster spoke on the Medical School Endowment Association and the letter from the American Medical Association requesting that we integrate our loan fund with the AMA ERF. Dr. Tank moved that no action be taken on this request. Dr. Sattler seconded the motion and it was carried.

Dr. Stransky spoke on the problem of chiropractic advertising in the Watertown area. Dr. Stransky moved that the problem to referred to the Interprofessional Health Council with the recommendation that they make every attempt to take some action on it before the end of the legislative session. The motion was seconded by Dr. Sattler and carried.

Dr. Stransky then discussed the existing laws concerning attempted suicides. He suggested that the law be changed to read that attempted suicides should be reported to the City or County Judge and that psychiatric evaluations be made mandatory as a follow-up procedure. Dr. Sattler moved that the matter be referred to the Mental Health Committee for their consideration and whatever action they recommend. The motion was seconded by Dr. Hayes and carried.

Dr. Stransky moved that the State Medical Association endorse the proposed law making seat belts mandatory in South Dakota. The motion was seconded by Dr. Brogdon and carried.

Dr. Reding reported on the South Dakota Physicians Committee and AMPAC. He urged that the councilors ask that everybody in their Districts join both organizations.

Dr. Reding moved that Dr. A. A. Lampert of Rapid City be awarded the Distinguished Service Award at the annual meeting. The motion was seconded by Dr. Hayes and carried.

Dr. Stransky moved that the Assistant Executive Secretary, Richard C. Erickson, and Administrative Assistant, Mary Alice Butler, be authorized to sign Association checks. The motion was seconded by Dr. Perry and carried.

A letter from Dr. John McGreevy was read concerning his resignation and the appointment to the Basic Science Board. The Council recommended that the names of Drs. Gordon Paulson, Warren Jones, T. R. Anderson, and Wayne Geib be submitted to the Governor for his consideration.

A discussion was held on the proposed four year medical school to be located at Sioux Falls. Dr. Sattler moved that the Medical Association reiterate its previous position on a four year school. The motion was seconded by Dr. Hohm and carried.

Dr. Stransky moved that the State Association request that the Harold Diers Company submit yearly information to the Council on their financial operation and that the Medical Association should act as an arbitrator on all disputed claims. The motion was seconded by Dr. Tank and carried.

The meeting was adjourned at 5:40 P.M.

PHYSICIAN NEEDED, INTERNIST

Fourteen man Iowa group has opening for Board qualified Internist. City of 30,000, new Clinic Building, complete laboratory and X-ray. Partnership in two years — salary open. Write Box A1, South Dakota Journal of Medicine and Pharmacy.

This is your

MEDICAL ASSOCIATION

NEWS • NOTES • • • BIRTHS • • • CHANGES • NEWS

Pop's Proverbs

A parable is a story — a **good** story is food for the soul.

NEWS NOTES

Dr. V. A. Zanderson, formerly at Herreid and Sioux Falls, has located at Woonsocket in the Whiting Memorial Clinic.

* * *

Dr. P. E. Lakstigala, White River, has announced that he will maintain an office in Winner, three days a week.

* * *

Dr. James Monfore has opened an office in Winner, for the general practice of medicine.

* * *

Doctor R. W. Roesel, Winner, has closed his surgical practice in that community and has associated himself with Dr. Carl Garside in Chicago. Dr. Roesel had just completed two years of practice in Winner.

* * *

U. S. Public Health Service will hold courses on Chemical and Biological Defense at Fort McClellan, Alabama. Classes run six days and persons interested in public health or civil defense may enroll. Classes start February 25, March 25, April 22, May 13, and June 17. Write executive office for application.

* * *

The twenty-sixth annual meeting of The New Orleans Graduate Medical Assembly will be held March 4-7, 1963 at the Roosevelt Hotel in New Orleans. Registration fee is $20.00, and registration is limited to white physicians who are in good standing in their local medical societies. The program is acceptable for a maximum of 29 hours Category I postgraduate education by the American Academy of General Practice.

* * *

A discussion of current communicable disease problems was presented by Mr. Ben Diamond and Mr. Norman Bredesen at the January 8th meeting of the 7th District Medical Society.

* * *

The Fifteenth Annual Teaching Seminar of the International Academy of Proctology, will be held March 16-21, 1963, Las Vegas, Nevada. Contact Jacob Reichert, M.D., President-Elect, Phoenix, Arizona, for further details.



PIERRE DOCTOR BAGS BOBCAT

A deer hunt is not the time to be attacked by a bobcat, however that is exactly what happened to **Doctor Charles Swanson** of Pierre, South Dakota. Fortunately, Doctor Swanson killed the cat as it was charging him. Contrary to some opinion, the cat did not die of fright. Doctor Swanson is shown with his cat at his cabin in the Black Hills.

HEALTH INSURANCE CONTINUES INCREASE*

In 1961, more Americans than ever before had voluntary health insurance to help meet the expenses of health care. Over 135 million people — 74% of the U. S. civilian population — had some form of protection against the costs of hospital or medical care. At the same time, more than 43 million wage earners were protected by insurance or other formal arrangements against the loss of income incurred during disability periods.

The average American with health insurance in 1961 also had greater protection than any time in the past against his hospital, surgical, and medical expenses. For example, of the more than 135 million people in 1961 with hospital expense insurance, 93% or 125 million people, were also protected against surgical expenses, and 69% or 92½ million had regular medical expense insurance. Five years earlier, only 87% of the persons under hospital expense protection had surgical expense insurance, and only 56% were covered against regular medical expense.

During 1961, the number of people with insurance company hospital expense protection represented 56% of the total number with hospital expense coverage. The number of people covered against hospital expenses by Blue Cross, Blue Shield and Medical Society-approved plans represented 40% of those with this form of protection. These relative proportions have remained stable over the last several years.

Similar stability is evidenced with surgical and regular medical expense protection. During the year, those with surgical expense coverage through insurance companies equaled 58% of the total so protected; those protected by Blue Cross, Blue Shield and Medical Society-approved plans equaled 37% of the total. Those under insurance company regular medical expense protection accounted for 45% of the total number so covered; those with this protection under Blue Cross, Blue Shield and Medical Society-approved plans accounted for 47% of the total.

Benefits for hospital, surgical, and medical expenses paid by all voluntary insuring organizations in 1961 totaled a record $5.5 billion, or over $600 million more than the year before. Benefits paid to replace income lost during periods of disability reached $855 million, bringing the 1961 benefit payments to an over-all total of $6.3 billion.

Total health insurance benefit payments naturally increase as more people come under health insurance coverage each year. However, benefit payments over the years have consistently risen at a much faster rate than the number of people protected. Health insurance benefits, as an illustration, increased 295% from 1951-61 compared to a 58% rise in the total number of insured persons.

Major medical expense insurance is another form of health insurance which serves people with more protection against health care costs. This insurance helps to pay for virtually all types of hospital and medical expenses incurred as a result of very serious illness.

* * *

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next scheduled examination (Part II), oral and clinical, will be conducted for all candidates at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board, April 29-May 4, 1963. Formal notice of the exact time of each candidate's examination will be sent him or her in advance of the examination dates.

Current Bulletins of the American Board of Obstetrics and Gynecology outlining the requirements for application, may be obtained by writing to the Secretary. All prospective candidates are urged to review the current requirements before applying for Board examination.

Diplomates are requested to keep the Board office informed of a change in address.

Office of the Secretary:
Robert L. Faulkner, M.D.
2105 Adelbert Road
Cleveland 6, Ohio

*Report of The Health Insurance Council's 16th Annual Survey.

OAA CHANGES EASE PROGRAM

Changes in administration of the Old Age Assistance medical care program approved by the State Welfare Commission, have eased much of the problem that physicians have had cooperating in the program.

The revisions provide for removal of the two visits per month limitation, allowing instead twenty-four visits in each fiscal year. The need for prior authorization on hospital visits or surgery has been removed.

Only tightening up done in the program was a new requirement that claims must be filed within 60 days of the month in which services were rendered.

* * *

ABERDEEN DISTRICT ELECTS OFFICERS FOR 1963

At the December meeting of the Aberdeen District Medical Society the following officers were elected for the coming year:

President—
Rainis Berzins, M.D.,
Bowdle, S. D.

Vice President—
B. C. Gerber, M.D.,
Aberdeen, S. D.

Secretary-Treasurer—
Paul R. Leon, M.D.,
Aberdeen, S. D.

Delegates elected for a two year term were **Drs. W. R. Taylor, C. L. Vogele,** and **R. E. Bormes.** Alternates elected, also for a two year term, were **Drs. G. J. Bloemendaal, G. F. McIntosh,** and **Carson Murdy.**

CLINICAL REVIEWS SCHEDULED

The Staff of the Mayo Clinic and the Faculty of the Mayo Foundation for Medical Educations and Research are again presenting Clinical Reviews next spring on March 11, 12 and 13 and March 18, 19 and 20, 1963. Because of the large number attending in past years, they are presenting two identical sessions on successive weeks in 1963 as they did in 1962.

* * *

CARDIOLOGY TOPIC FOR M.D. PROGRAM

A nine month tutorial program in Cardiology, September 15, 1963 to June 15, 1964, will be offered by the Institute for Cardio-Pulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, California. This will be an intensive academic effort covering the field of cardiovascular diseases and is especially designed for the practicing physician who desires thorough instruction in this field and for the physician who is finishing his period of formal training and wants a final intensive orientation in cardiology. For details, write: Executive Secretary, Institute for Cardio-Pulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, California.

* * *

HURON DISTRICT ELECTS OFFICERS

Members of the Fifth Medical District met on December 13th at the Inn Hotel in Huron.

Dinner, for the doctors and their wives, was followed by a short business meeting and election of officers. New officers for the ensuing year are: **William Hanson, M.D.,** President; **Ted Hohm, M.D.,** Vice President; **William Huet, M.D.,** Secretary-Treasurer and **Bernard Lenz, M.D.,** Board of Censors.

Mr. Ben Diamond, Director of the State laboratory at Pierre gave a short presentation on Venereal Disease Control, and introduced Mr. Norman Bredeson of the U.S. Public Health Department.

Mr. Richard Erickson, Assistant Executive Secretary presented forthcoming legislative topics.

* * *

NEW OFFICERS FOR BLACK HILLS DISTRICT

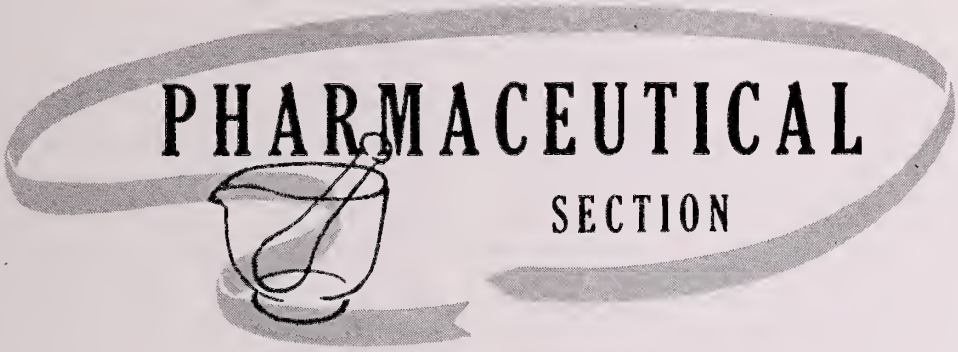
The Black Hills District Medical Society has elected the following officers for 1963:

Dr. Conrad Blunck,
President

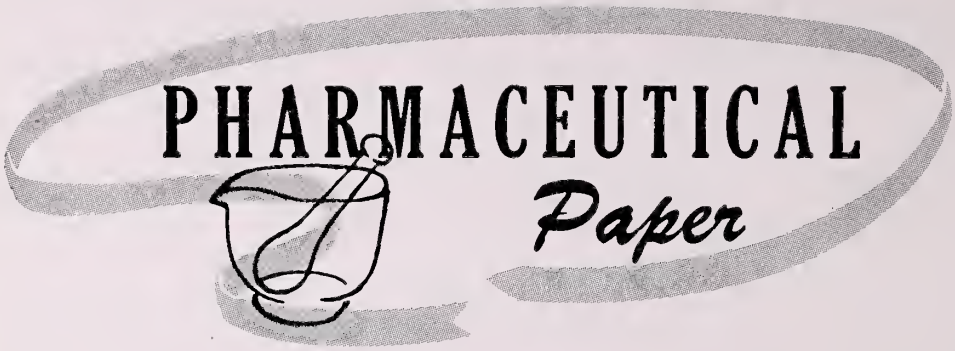
Dr. Arthur Semones,
Vice President

Dr. Harold Frost,
Secretary-Treasurer

Delegates to the State Medical Association are **Dr. S. F. Sherrill** and **Dr. Rueben Bareis** for one year terms; **Dr. R. C. Finley, Dr. A. M. Semones,** and **Dr. T. R. Jacobson** for two year terms. Alternate delegates will be **Dr. E. T. Ruud, Dr. J. F. Leeds, Dr. B. S. Clark, Dr. James Ritchie,** and **Dr. F. J. Gilbert.**



GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota



THE PHARMACEUTICAL INDUSTRY IN THE LIMELIGHT: A RECAPITULATION*

by
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The pharmaceutical industry, in recent years, has found itself continuously in the limelight. This is understandable. Over the past few decades, the industry's growth — thanks primarily to more effective, newer medical compounds — has been remarkable. The profits of some pharmaceutical firms have been good, although by no means exorbitant. These were twin beacons to catch the eye of Washington — rapid growth and good profits. Once Washington had interested itself in the pharmaceutical industry, it was inevitable that the public — through press, radio and television — would soon be looking in the same direction.

The Kefauver subcommittee put the pharmaceutical industry under the Klieg lights in December, 1959. It has not been out of the public eye since. This has been especially true in recent months while Congress has been engaged in the task of formulating new drug legislation. In this regard, the most recent development — as we are all aware — was the passage of the new drug bill by Congress last week.

Newspapers, of course, devoted a great deal of attention to the passage of the bill. This represented an accomplishment — a change. It was news. I propose to explore a different tack. I should like to talk to you about something which is not news because it does not change: the basic position of the pharmaceutical industry. I think that it is important that you as pharmacists—and as educators of pharmacists — know where industry stands on the basic questions which affect it and, indirectly, yourselves. I think you will want to know the reasons behind the industry's attitudes.

Therefore, I propose to touch many points. But do not be alarmed. My intention is merely to explain, not to belabor. My purpose is to show that there is both logic and consistency underlying the attitude of the pharmaceutical industry towards new legislation; towards efforts to require the use of generic names in prescribing; towards questions of prices and profits, and towards patents. There is, incidentally, an association between the patent question and industrial espionage. I should also like to tell you about this.

The best way to begin, it would seem to me, is not at the beginning but with an end. I should like to put an end — for our discussion, at least — to a piece of nonsense which we hear all too often. This is the categorical statement that the pharmaceutical industry

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opposed strengthening drug laws. It definitely did not. The industry worked closely with Federal agencies and with members and committees of Congress, not to emasculate present and proposed regulations and legislation but to revise them constructively. Certain aspects of some proposals, the industry opposed. Others it backed with all of its force. The important thing in making any judgment is to keep the account straight — to rely on the record rather than to resort to the cliche.

Drug Safety

The record — for one thing — shows the pharmaceutical industry in complete agreement with the professions of medicine and pharmacy on the question of drug safety. With drug safety, all are agreed, there can be no compromise. Medical preparations must be as safe as science can make them. We strive for maximum safety. But we must make no pretense that drugs can ever be completely safe. You, being interested and concerned with pharmacy, and we, as manufacturers, are fully aware that the safety of prescription drugs is not absolute. But apparently large segments of the public and certain Congressmen do not understand this. As a consequence, we continue to hear expressions of indignation that drugs should have side effects and that, occasionally, unfortunate incidents stem from their use.

You, associated with pharmacy, are in an excellent position to help us clarify the drug-safety question for those who continue to misunderstand. We must reiterate — as often as it may be necessary — that it is a contradiction in terms to think of prescription medicines as perfectly safe. The prescription, after all, serves the purpose: it assures that a potentially harmful compound remains under the careful supervision of doctors and pharmacists. The point is evident. Yet it is frequently overlooked by the public and in Congressional debate. I also hope that we can get the public to realize that drug safety must be measured with a sliding scale. The nature of the illness to be treated is very much a factor in evaluating the safety of a compound. We must point out that medical agents of proven worth against life-threatening illnesses often have side effects which would outlaw their use as simple headache remedies.

Why have I dwelt on a point as self-evident as drug safety? I have done so because confusion over the elementary questions—safety, clinical testing and the like — continues to muddy the legislative waters in Washington. This confusion makes straightforward presentation and clear-headed evaluation of industry's point of view infinitely more difficult. It permits emotionalism — even outrage — to substitute for logical thinking.

Logically, it is perfectly evident that a new prescription product must be tested by qualified clinicians on a number of selected patients before it is made available to physicians generally. Pharmacists know the sequence. A compound which shows promise is tested extensively in animals. If it passes muster — and very few do — it is given over to a small, carefully selected group of clinicians. These doctors will try the drug in cases in which they have reason to believe it may be beneficial.

The testing clinicians, as you know, are not employees of the company which manufactures the compound undergoing evaluation. They are independent investigators, usually specialists. Their decision whether to utilize the compound — even whether to participate in the testing — is strictly voluntary. It is based on their individual professional interpretations of animal data and other information provided for them by the company. The clinical test, therefore, is one aspect of the practice of medicine. The physicians who participate, it must always be remembered, are precisely that: physicians. They must place nothing ahead of the well being of their patients.

Therefore, what are we to make of the frequently repeated but basely degrading phrase, "human guinea pig"? Evidently, this is another case of emotionalism getting the upper hand over clear thinking. There have been abuses of clinical trials, as we are all aware. And there exists a definite need for improved communication of clinical data. But communication of clinical data is a technical point. The concept is far removed from that implied in the completely unjustified phrase, "human guinea pig."

A person in the public eye — or an industry — must become accustomed to a certain amount of misrepresentation and abuse. Therefore, it might be asked whether I am not being merely thin skinned — overly sensitive to criticism — in pointing to the mis-

leading remarks spawned by discussions of drug safety and clinical testing. After all, it will be argued, legislation has now emerged which — in many ways — is constructive. It does provide for additional safeguards. And I believe that most members of the pharmaceutical industry — although not all — consider the new legislation to be in the public interest. Included, I acknowledge, are provisions which the industry considers to be unnecessary and somewhat encumbering. Outweighing these, the measure has genuinely constructive provisions dealing with drug safety and clinical testing. Equally important, nothing is included which would deal a vicious blow to drug-industry research and progress, as — for example — the patent-restricting provisions of the original Kefauver bill would have done.

Therefore, I seem to be contradicting myself. I have pointed out the highly emotional content of frequently heard remarks about drug safety and clinical testing. I have implied, I believe, that emotionalism is a shaky base on which to build legislation. Yet I have said that, by and large, the pharmaceutical industry is satisfied that the safety and clinical testing provisions of the new legislation are in the public interest.

I believe that we are getting good legislation with regard to safety and clinical testing because the basic issues are easily appreciated, in spite of the emotional camouflage. From the actions of Congress, it would appear that most legislators understand. But I have noted previously that a large segment of the public does not yet understand and ask that you — as pharmacists — help in getting these points across. It matters. Unless we make these points well, we are bound to have more time-consuming and nerve-rasping discussion which can only obscure the major issues which still confront us. Equally important, the hint of suspicion and animosity which remains in the thinking of many individuals will not disappear until all of the public is convinced that the manufacturers of prescription products are deeply concerned with the safety of those who consume them.

It is useless to pretend that emotions do not influence legislation. They do. That is why it is important to clean the slate— to erase lingering suspicions about drug safety and testing. Remember: many points of misunderstanding of the drug industry are not touched upon in the new bill. They will be back. Let us do what we can, before the next Congress convenes, to provide the public with the facts and to get back on an even keel emotionally. This would permit the undecided issues to be considered on their own merits.

Prices and Profits

Unresolved by the new legislation is the question of drug prices. Nor have we heard the last of two closely related issues: mandatory generic-name prescribing and compulsory licensing of new products to would-be manufacturers. I have already noted that the new legislation does not contain a compulsory-licensing provision. But few in Washington think for a minute that the issue is dead. While the question of profits — in its many costumes — may have left the stage for a moment, it certainly has not left the theater.

The price-profit issue, as you are aware, can generate almost as much emotional voltage as drug safety. And it is infinitely more difficult to explain. We already know what we face. More easy — but completely misleading — generalizations about huge profits and out-of-line prices. More accusations which reduce a complex process to a handy formula by distorting the facts.

A simple comparison of the cost of raw materials with the retail cost of a finished medical product demonstrates very little. Nonetheless, each of us has seen such figures utilized fallaciously or unwittingly as the basis of allegations of enormous drug profits. We will all hear such statistics again. How should we answer to try to get the discussion back on a rational plane?

First, we can point out that the argument takes no account of production costs. These can involve huge expenditures for the physical plant, for basic materials, for wages and for many other things. As for wages, we would do well to point out that pharmaceutical manufacturing requires an extraordinarily high percentage of skilled persons, since it is research and service oriented. It requires relatively few production-line workers. As a consequence, the labor cost per individual worker is exceptionally high. This — in itself — can make certain flat comparisons with other types of industries virtually

meaningless.

At the manufacturer's level also are the costs of research, including the expenses of clinical evaluation; costs of packaging; costs of promotion; costs of distribution. And we must also include the manufacturer's taxes and profits.

Profits in the pharmaceutical industry are good, but not exorbitant. The authoritative survey of the First National City Bank of New York showed the industry's average profits for 1961, after taxes, to be 10.6 per cent. If this is a good profit, there are reasons why it should be. The successful manufacturer must innovate. He must bring better products to the market continually. If he doesn't, someone else will. So the drug manufacturer finds himself heavily committed financially to research projects intended to make his own products obsolete. Through this process, the public gets better therapy. But it takes money. It takes profits both to have funds available and to attract investment capital.

This would be an inappropriate occasion to dwell on pharmaceutical industry profits and the socially useful mechanism they keep in constant motion. They are, however, a matter of record. If I may, I'd like to send each of you a copy of our annual report, so that you can see for yourselves exactly what the profit picture in one company is. Also, let me send you each a copy of a booklet describing major research accomplishments of our company's scientists and please bear in mind that profits are the fuel for this endeavor.

Patents

Caught in the middle of the price-profit debate are drug patents. This is unfortunate, for drug patents serve a very useful function. They force originality in competitive research. They reward the innovator. It is difficult to imagine an individual — or a company — more deserving of reward than the one contributing to medical progress. Yet critics of the drug industry take the opposite view. They argue that no one should be allowed to profit from an invention which is of great potential benefit to mankind. The argument is noble in its intentions, but it ignores reality.

Better prescription medicines are created, in large measure, because pharmaceutical companies are willing to risk the millions of dollars it takes to equip and staff major research efforts. American pharmaceutical companies spend more than a quarter of a billion dollars a year on research. They are willing to take expensive risks because the profit to be made with an improved drug can be excellent. And this does not mean exorbitant prices; it means a huge market.

Without patent protection, such research would be impossible. Research would also suffer from any move to require patent holders, after three years, to license all qualified applicants in return for a rather small royalty. Few firms would be interested in making a major research investment unless they could be sure of a major share of the market for the drugs they develop. With compulsory licensing, the better the drug, the smaller would be the inventor's share of the market. Financially, a company's best research course could very easily be to wait for someone else to make the discoveries. Imagine the stagnation which would result.

I sometimes wonder whether we, as a nation, realize the debt we owe to patents. Without patents to stimulate invention, it is inconceivable that we could have achieved our present standard of living. We owe our present to patents. Even more, we rely on them for our future.

As you are aware, Western Europe has created its own mass market. So has the Communist bloc. America's economic leadership is being severely challenged.

But American industry has been preparing its defense. Its defense is greater initiative — more ability to get there first. By turning to science — by utilizing in an unparalleled fashion the teamed talents of research and developmental experts — it has made a major enterprise of discovery. Research and development activity in this country — entirely in private, competitive hands — by now totals $10 billion yearly. Here is unlimited opportunity for the enterprising. But here, also, is unlimited temptation for the unscrupulous. Our growing dependence upon research has spawned the research spy.

Industrial Espionage

What he steals looks like very little. A few notes scrawled on a piece of paper. A crude sketch. Even a formula committed to memory. Yet those who are intimately familiar with industrial espionage believe that it represents a menace of major proportions.

Let me illustrate by citing an example. It is from my own company. And you may have heard of it because it reached the public print.

As you know, our research into health questions sometimes takes us into the animal field. A few years ago, our research chemists, biologists and veterinarians launched a quest for a compound which would combat a parasitic disease which was costing the poultry industry in this country alone approximately $100 million annually. They found such a compound. And over a period of a decade, it built up a market of $10 million a year. But the parasites became resistant to the compound. And several competitors came forward with better agents. The parasite eventually defeated these, too, as well as a second compound discovered in our laboratory.

At this point, a team of our chemists — the most experienced group in the world in fighting this parasite — developed an entirely new and highly imaginative weapon. In preliminary tests, it worked. But the compound was from a large family of molecules, and not the best for the job. So the chemists made variations — 150 of them. All were evaluated. Some were too toxic; some too unstable. Finally, the research staff made its choice.

Chemical work started immediately on a better method of synthesis and pilot plant operations and process development work were begun. Safety and metabolic studies were launched; dosage levels were determined. Finally, after a year and a half, new drug applications were filed with the Food and Drug Administration. By then, expenditures had totaled several hundred thousand dollars.

At this juncture, one of our people attending a scientific meeting heard a paper on a compound which sounded very much like ours. The speaker, who claimed to have discovered the compound, headed a research organization which was hardly more than a token. Lacking manufacturing facilities, he planned to sell the compound to competitors of ours. From one of these competitors came confirmation that the compound was, indeed, ours. The odds were astronomically against anyone else's coming up with this particular compound. There was an inescapable conclusion: our research had been stolen.

But how to find proof. The thief was working fast. He had already filed patent applications in several nations and was actively selling the compound to five companies — two here and three abroad.

Then we got a one-in-a-million break. A French company with which he was negotiating turned out to be one we were negotiating to buy. This company turned over documents which had been peddled by the research thief. These papers had wording and drawings identical to those in our own files— even to mistakes.

Another fortunate break: one of our security officers — through skillful detective work — tracked down the employee who had been supplying information. And the employee confessed.

But we did not have the master spy. He left the country. Indicted here and abroad, he went to a third country. There, he filed suit against us, charging we were the ones who had stolen his invention. When we win this case, will he move on? Will he peddle the research secrets behind the Iron Curtain? There are indications this has already happened.

I have cited this example to provide you with a true illustration. If this sort of activity were rare, it would not be a cause of deep concern. But industrial espionage is not rare. And when we transfer our attention from isolated cases to the general problem, we see that there is genuine cause for alarm.

Those who steal industrial secrets deprive the innovator of credit for his accomplishment and of tangible reward for his risk and effort. Those who utilize stolen secrets are at a competitive advantage because they have no costs of research and development. Furthermore, thieves attack a scientific organization at its most vital point. The many members of research teams must communicate freely — both orally and in writing. They must be able to store and retrieve data easily. All of this plays into the hands of the research spy.

And look at the commodity stolen! As knowledge separated from its paper, it is intangible. It cannot be seen, found, returned or destroyed. It can be used forever. Industrial thievery is a subtle and sophisticated wrong.

It is important to note also that the legal penalties for industrial espionage are not yet

commensurate with the harm which such spying causes. A secret, to the right buyer, is a commodity of enormous value. Not so to the law. Intangible knowledge — regardless of its value — is not covered by the National Stolen Property Act. Stolen documents and samples must of themselves have a value of $5,000 or more to qualify. And what is the value of a sample of an unestablished chemical compound? State laws also concentrate on touchable things.

The answer — of course — is better laws in this field. And this will come if the public can be made to understand the real extent of the wrong.

So we are back to a familiar theme. Again, the plea is for missionaries. Once again, we must try to reach the public with an important message.

In retrospect, I find that what we have been discussing is the harm which can come to industry — specifically, to the pharmaceutical industry and pharmacy as a whole — through public misunderstanding. Confusion about drug safety and testing led to a harmful attitude of distrust. Misunderstandings about drug prices have compounded this sentiment. Finally, we have seen that unless the public comes to recognize the menace posed by industrial espionage, we run the risk of having a vital force for progress sapped by treachery.

In each case, the antidote to the danger is facts. You, in pharmacy, have the ear to the public. Thank you for letting me talk to you so frankly.

THE COST OF PROGRESS

The drug industry spends more than $100,000,000 annually for research, and no other industry in this country spends that much. It must be emphasized that for every thousand products researched by the drug industry only 40 or 50 reach a marketable stage. Because I am a physician who started practicing medicine before the days of the wonder drugs, I know their real value. As doctors, we have an understanding of the worth of these drugs. We can do so much more with these drugs today than we could with the drugs available to us 15 years ago. All of this means progress. Of course, it also means greater costs. — Edward R. Annis, M.D., in **Pennsylvania Medical Journal,** Oct. 1962.



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Cold remedies? ☐ Prescriptions? ☐

HOUSEHOLD CLEANING AGENTS (Next most common cause)
Are they kept on high shelves? ☐
Are any stored on some shelves as edible products? ☐

PETROLEUM PRODUCTS (gasoline, kerosene, furniture oil)
Always tightly capped? ☐
Never stored in food containers? ☐

PESTICIDES (highly toxic)
Always returned to where they're out of reach? ☐
Always kept in original, labeled containers? ☐

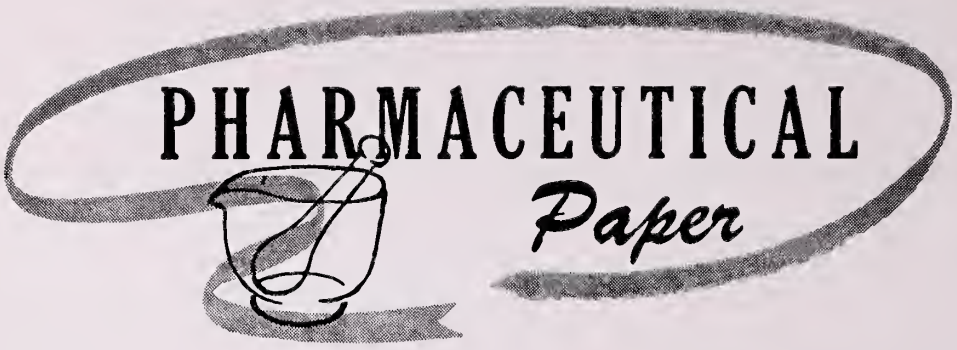
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CHANGING TRENDS IN PROVIDING PHARMACY SERVICE*

by
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Change is a popular word and rarely a day goes by when we do not read an article or hear a speech discussing the evolution and revolution of change. Change has been with us ever since the first settler landed in this country and hopefully will continue, for progress does require it. However, it is important to recognize that not all changes are desirable. It is not living in a changing world that is so significant today as is the speed with which these changes are taking place. What used to take 50 years to occur now takes 5 or 10 and what used to evolve in generations now occurs several times in one's lifetime. Thus it is essential that we make every effort to understand the changes that are occurring and be informed and aware so that proper individual actions can be taken to compensate for them.

The changes we are discussing today involve that of providing pharmacy service and the pharmacist is being bombarded with advice and guidance to meet them, pushing him, pulling him, driving him, worrying him and in the long run creating an individual who really is not charting his course of action but winding up as a captive of his environment. Let us make it very clear that the needs for pharmacy service have not changed over the many years of the existence of our profession. In fact, today more than ever before the people need the high degree of personalized professional service that they have received from the pharmacist in the past. The need for this service, with the more effective and yet more dangerous drugs, has been pointed out most vividly by recent events. How well this need is met will determine the future status of this profession of pharmacy. If the need has not changed, then what has? Primarily, it is the atmosphere in which these needs are supposed to be met and how the very elements which make up this atmosphere have prevented the full realization of these needs.

In many areas and in many instances the basic concepts governing a profession have been completely submerged by economic considerations. By the failure of the profession of pharmacy to really recognize its function and role and to protect this by sound and sensible organization. Non-professional elements were allowed to so permeate the field that now they, in some areas, have become the primary force. This has developed directly from the fact that pharmacy enjoyed a tremendous growth over the last 20 years. In that period of time the dollar volume in the pharmaceutical field has increased better than 1,000 per cent. It is this rapid growth which has provided the economic incentive to attract these people and it was the pharmacists' failure to recognize what was going

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on and to react rapidly which allowed them to gain the foothold. The great increase in the dollar volume of the average pharmacy has encouraged the entry of new and difficult elements. The supermarket with a prescription department, discount centers with drug and prescription sections, closed door pharmacies, mail order pharmacies, union pharmacies and what have you. All of these outlets have entered the picture either because of the apparent profits to be made or, and what we believe is the primary reason, because the recent furor concerning drug costs has caused great interest in this field, thus providing a relatively easy method for such an outlet to establish a price image and thus attract customers to mass merchandising operations so as to sell the many products available. Essentially, pharmacy and particularly pharmaceuticals, have been used and this has caused competitive pressures which are causing problems which the average independent pharmacist is not equipped to meet.

To solve these problems, pharmacists are being told that they should emulate the competition. They should out super the supermarket, out merchandise the chain and out discount the discounter. All of these approaches offer little hope for they further drive the pharmacist from the basic reason for public support; namely, personalized professional service and in effect encourages amateurs to play in a competitive game with professionals. How the individual is to out merchandise the merchandiser with all of his resources and experience, is beyond me. To do as some have suggested, use the professional cloak to surround the merchandising effort, can only result in the loss of public respect for the professional aspects of our calling. Today the pharmacist must make up his mind. Does he really want to be a professional or does he want to be a business man? There is absolutely nothing wrong with either but to vascillate between each does not allow successful realization of either one.

Pharmacists are being encouraged to operate larger and larger operations. In fact wholesalers and others are making it easy for them to get started in such operations. Once he does, he becomes locked in. What does one do with 10,000-50,000 square feet? He must put in all kinds of merchandise to fill it, thus he is required to manage a larger and more efficient type of merchandising operation in order to have a place to practice his profession. The more successful he is in this endeavor, the less time he has to practice his profession. If he is successful, to control this big operation, he must hire other pharmacists to practice his profession for him and he winds up running a business in order to maintain a place in which other pharmacists can practice their profession. If he is to continue to grow, he will seek additional such opportunities and soon becomes a small chain himself. To bring this to its ultimate we can thus expect to see more employee pharmacists and fewer operators and some of the wholesalers who have made this possible will then wind up with an element that will make every effort to by-pass them. And yet, if a pharmacist is to be influenced by the advice given him today and to seek these large operations, he must recognize that in turn he will be driven further from the duties for which he was educated. We can have no argument with these developments provided the pharmacist knows what to expect and that he recognizes the reasons and sources of advice that are being given him.

However, we are not convinced that this is really what the public wants despite the many indications of this by the elements that have an axe to grind. We sincerely believe that there is an important need for pharmacy graduates to meet a real public health need in the community; that maybe pharmacists should be pointed toward entering a practice when they graduate rather than going into business. The utilization of the pharmacist's training and ability to perform in health matters of his community has not been explored in the least and only now is there talk of surveys which would explore these areas and broaden the professional horizons of the pharmacist.

With the more potent drugs, the public needs someone who is well versed in the drug products and the drug history of the individual. Someone is seriously needed to stand between the public and the medical profession and the industry so as to see that in the use of drugs the public interest is met. Too few individuals have made it really clear to the pharmacist the need of and the type of professional service he can render to his community for this is an effort that does not

need more fixtures nor wide classifications of merchandise.

It should be stated very clearly that in studies which we have made in the American College of Apothecaries, despite widespread and new competitive elements the pharmacist who is practicing his profession, who is doing a professional job, who concerns himself with public health matters, is by and large filling more prescriptions today and is increasing his volume. In certain cases where this is not true, it is not discount competition that is chiefly responsible but effective independent competition. Admittedly, some pharmacists are being hurt but why is this? Primarily because they are not giving the kind of personal prescription and professional service that differentiates them from the merchandising element. In many cases this service is no different and the atmosphere in which they practice still conveys the impression of a merchandising emporium. How can the public be expected to differentiate if there is no basis for differentiation?

Now before our comments are deprecated by the old bromides which we have heard and seen lately, let us make it clear, we are not advocating that every pharmacy overnight turn into a prescription pharmacy. We are just as well aware of the statistical facts of life which today would not make this feasible. What we are advocating is that we look toward the future, that we adjust our sights to the needs that will be upon us, not in the next generation but in the next decade and pause to consider what we are doing. Most certainly, today every pharmacy cannot be an exclusive prescription pharmacy but most certainly most pharmacy owners could work toward rearranging their thinking of pharmacy to make it as personalized and professional an institution as possible. He can emphasize those areas which demand personal attention, the prescription department, the over-the-counter remedies, the prescription accessories, the health supports, cosmetics and a few other personal service departments which would differentiate him clearly and decisively from his merchandising counterpart and he can look at what is coming and adjust to it.

Let us just take a little look into the future. By 1970, our population will exceed 210 million or over 25 million more people will need our services. Our senior citizens will increase almost 50% in a decade. These 20 million oldsters will require more medical care. New drugs will be developed, new areas of therapy will be uncovered, all of which will increase the need for our services.

It is estimated that there will be a 250% increase in prescriptions in this decade. This would mean that by 1970 there will be about 1.7 billion prescriptions filled per year. If we develop other areas such as dentistry and podiatry and if governmental programs such as the Kerr-Mills, are properly planned, this figure could even go higher. But even at 1.7 billion, this means about 12,000 prescriptions per pharmacist per year or 40 prescriptions per working day. We are convinced that in no way will the pharmacy schools be able to turn out anywhere near the number of pharmacists needed and also we cannot visualize any marked increase in the number of pharmacies so that by 1970 the average pharmacy will be filling about 110 prescriptions a day which could full well occupy the complete time of the pharmacist. If pharmacists recognize what is happening and adjust to insure their getting their proper share, their future could be bright. Otherwise this future potential could well be exploited by those who use pharmacists rather than being pharmacists.

Also we must mention that there will also be a relative shortage of physicians and some of the functions of today's physicians could well be taken over by properly trained and properly qualified pharmacists.

Thus, I strongly believe and statistics bear me out, that rather than attempt to emulate the merchandiser, the pharmacist should do all he can to emphasize the diferences. However, he must make certain that there are differences and the public knows about them. The recent case by the Justice Department in Los Angeles brought to light certain figures which indicate that in spite of all the hoopla and efforts, the chains have not made any real dent in capturing prescription volume. It was shown that although Thrifty Drug had 21.7% of the Los Angeles "drug volume," whatever that is, they had only 10% of the prescription volume. Actually, in the area, independents accounted for only 55% of the total "retail drug sales" but accounted for 76% of the total prescription volume. Thus the chains in the

Los Angeles area accounted for only 24% of the prescription volume and this included a prescription chain having 26 prescription operations. It seems logical that pharmacists should do all they can to insure maintaining and even increasing this percentage and this cannot be done by "joining them."

Many methods and suggestions are being thrown at the pharmacist among which is a recent craze toward cooperative joint advertising of "independent retailers." We enter a word of caution. A jungle-type mass merchandising ad with a block extolling the virtues of pharmacy is not going to project a professional image. Nor is it going to identify the pharmacist as a professional individual to his patrons. If anything it is going to cloud the public's mind and could well do more harm than good. It is typically contrary to the personalized approach which we feel is necessary.

There are changing trends in providing pharmaceutical service. We have not mentioned the hospital pharmacy and its impact but we are sincerely convinced that the major responsibility of providing pharmacy service in the future will still fall on the pharmacy in the community. With a larger prescription volume, the pharmacist will be thrown in greater contact with the medical profession. He will have greater opportunities to influence and guide physicians' prescribing habits. But opportunities are not realizations. How well these opportunities are realized will depend on how well the pharmacist equips himself and maintains himself. A worthwhile and definite program of postgraduate education will have to be followed.



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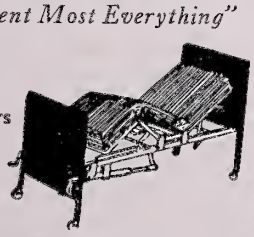
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New methods will have to be found to keep informed and be informed. The pharmacist is going to have to take a much more active interest in what is being prescribed for patients, in what dosages and with what other medications. He is going to have to assume other public health responsibilities and in turn the economic considerations will follow. Certainly there will be frustrations but if we analyze the situation, if we provide the public with the type of service they need at sensible and evenly distributed fees, the realization will be possible. The changing trends will produce problems but also will produce the real opportunity for pharmacy to devote more and more of its time to areas where their training can be utilized. For those that have some vision, this is obvious. For those who are discouraged, we urge another good hard look. For this opportunity is available for most and, in a profession, it is the individual's action that really matters.

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PRESIDENT'S PAGE



The New Year, 1963, brings with it new challenges and many new things of interest to all South Dakota druggists.

Of special interest is the new Federal office, which will pass on all requests to test new drugs on human beings. The new director is Dr. Frances O. Kelsey. This is part of the re-organization of the Food and Drug Administration, which includes dividing the Division of New Drugs into five branches. Dr. Kelsey will supervise the Investigational Drug Branch. This branch will evaluate reports of clinical tests of new drugs, which manufacturers will submit, in compliance with regulations.

The Food and Drug Administration will include a Controls Evaluation Branch, a New Drug Status Branch, a Medical Evaluation Branch, and a New Drug Surveillance Branch to review inspectors' findings.

Other new items: the new 1963 legislature and its action is of interest to all South Dakota citizens.

Also, activity is reported in Pierre on plans for the 1963 South Dakota Pharmaceutical Association Convention. One-hundred percent attendance of all registered pharmacists is the goal of the Convention Committee.

Sincerely,

L. B. Urton

President



Advances In Drug Research

ANTIBIOTICS: FROM DISCOVERY TO THERAPY

The cost of developing a newly discovered antibiotic to the stage where it is a practical, useful medicine can be twice as high as the cost of making the discovery itself.

The original research cost for the broad spectrum antibiotics produced by Lederle Laboratories, a Division of American Cyanamid Company, totaled almost five and a half million dollars, while their development costs as of 1961 ran more than ten million dollars.

Although 5,000 antibiotics have been discovered in the past fifteen years after screening millions of soil samples, only 17 have proved to be of medical value. But this is merely the discovery phase of research and development. The biggest part of the task of getting a useful antibiotic to the patient has just begun.

When the medical value of its broad spectrum antibiotics was established, Lederle had to develop strains that would produce enough of the antibiotic to make a commercial process possible.

Antibiotics are not man made. They are manufactured by micro-organisms. The ability of the originally discovered organism to produce the wanted antibiotic substance may be so poor as to make large-scale production unfeasible. The organisms become truly valuable only when they can be made to produce efficiently. For example, when Aureomycin (chlortetracycline) was introduced in 1948, the price per 250 mg capsule to the pharmacist was approximately $1.55. At present, due largely to development work, this price is down to about 23 cents. Certainly, production today with the original organism and processes would be economically unfeasible and competitively impossible. As another example, if the original penicillin mold was produced commercially today, it would take 26 gallons of fermenting solution to make one minimum dose of penicillin. Fortunately, through persistent research, a more highly productive strain of penicillin was found.

There is no established method for developing highly productive antibiotic strains. In some cases they are never found. Again, research is pitted against the field of chance. Merely following established laboratory procedures by no means assures success. For example, nearly 500 mutants of the original strain of Streptomyces aureofaciens were made by treating it with such things as ultra violet light, X-rays, and nitrogen mustard, to change its genetic character. Each mutant had to be grown in an assortment of solutions under varying environmental conditions.

An antibiotic mold is not unlike any other living thing. It requires carbohydrates — starch and sugar — proteins, vitamins and minerals. Scientists have to choose which will make it grow best. It is a constant battle to keep the organism growing and to keep it producing the antibiotic. It might grow very well but not produce any antibiotic.

A variety of nutritive substances, including corn steep liquor, casein, meat extracts, fish

solubles, may be used to "grow" an antibiotic. The exact nutrient balance is ticklish to determine. Factors, such as the acidity or alkalinity of the solution in which organisms are grown, also can upset the growth of an antibiotic.

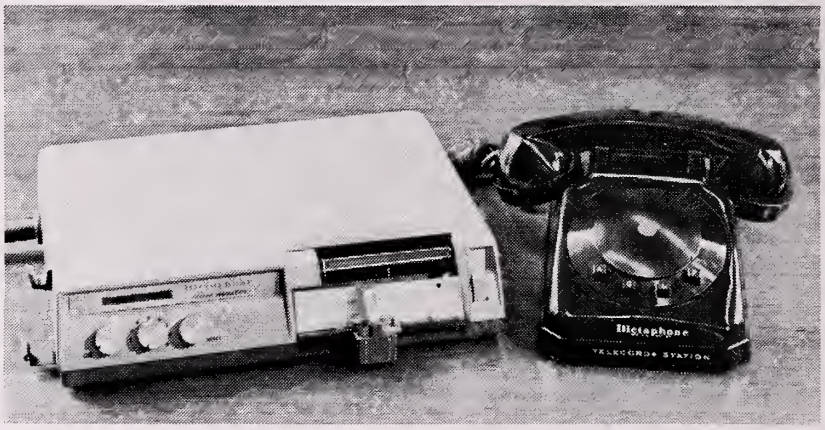
When Lederle researchers discovered a strain that produced the antibiotic more lavishly, making commercial production possible, engineers had to transfer the whole process from laboratory flasks to giant fermentation tanks. They faced the paradoxical task of mass-producing the antibiotic which was only available in microscopic quantities. Yet precise laboratory techniques had to be maintained.

To obtain the pure antibiotic, they had to research and develop a series of procedures which, even today, are extremely complex. Micro-organisms had to be filtered out. Solvents had to be found to extract the antibiotic from the fermentation liquid. They had to find methods for crystallizing it, drying it, grinding it, and analyzing it. It took two years to develop and perfect methods for fermenting and purifying the antibiotic, Aureomycin. Improvements are still being made fifteen years later.

Today, in the manufacturing process to produce and purify an antibiotic such as Aureomycin, a production cycle of three to five months is required. To make sixteen capsules of Aureomycin, even today, more than five pounds of the fermentation solution must be processed.

The development phase of research is a continuing process; there is no point which can be considered final. In a competitive situation leadership in product development is no less important than product discovery — in some cases more so. And product development work in most cases involves more people, more processes and more time than product discovery.

Doctor, NOW You Can Dictate As Easily as Telephoning

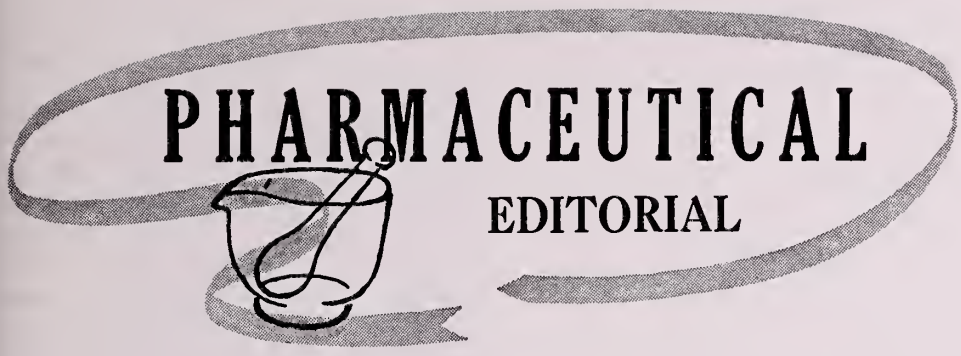


Every doctor uses the telephone for oral communication. Now dictation can be phoned just as easily — with typewritten copies the quick end result.

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A VITAL CONSULTANT TO HIS NEIGHBOR

(Medicine at Work, December, 1962)

Trenton pharmacist James E. Delahanty offers more to his customers than prescribed drugs. He also serves as health consultant, and his information occasionally is more valuable than his medicine.

Delahanty's is one of more than 100 New Jersey retail pharmacies designated as Community Health Information Centers in a unique project now operating under auspices of the Rutgers University College of Pharmacy extension service. These pharmacists display informative pamphlets dealing with health subjects, and record the number and types of health questions asked by customers. They also emphasize the potential danger of "doing it yourself" rather than obtaining a physician's advice about personal health problems.

This program is made possible also through the cooperation of drug manufacturers, insurance companies, and health agencies, which provide the booklets for distribution from a special rack in the store. All concerned are motivated by the fact that many persons fall prey to the "costly time lag" — often caused by misinformation or lack of information — between affliction (or infliction) and treatment. (See Medicine At Work, July, 1961.) Because an estimated ten million people, the ailing as well as the healthy, enter America's 55,000 drug stores each day, the New Jersey pharmacists are agreed that here is a good place to start health education for the public.

Also agreeing is Francis Boyer, board chairman of Smith Kline & French Laboratories, pharmaceutical manufacturers in Philadelphia. Several weeks ago he told members of the National Association of Retail Druggists: "You pharmacists are important and respected in your communities. You are experts in your field. You perform a vital public service."

This is why the pharmacist is able to play an effective role as neighborhood health communicator and consultant.

CLINICAL TRIALS OF NEW DRUGS

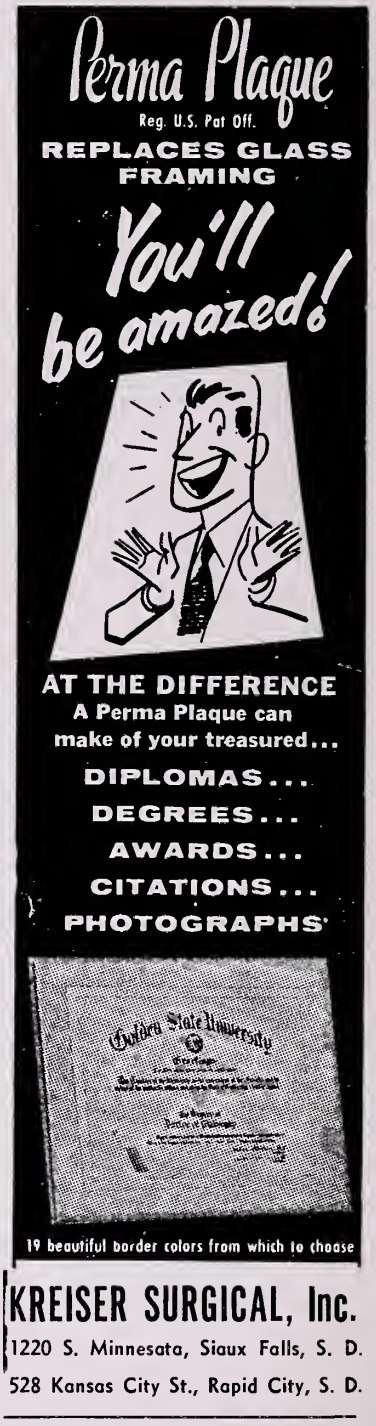
We find many references to "human guinea pigs," surely one of the most frightening and degrading terms ever invented. Generally, the term refers to the first use, in the hands of a highly competent doctor, of a compound which had been studied extensively in animals and which had shown promise of being useful as an agent in humans. This should be noted: the physician himself — acting with complete independence — decides whether he will participate in the evaluation of a new compound. And then he makes his own professional judgments as to its usefulness and effectiveness. In other words, while clinical trials are necessary to industry, they are not a process controlled by industry. — John T. Connor, President , Merck & Co., to American Hospital Association, Sept. 18, 1962.

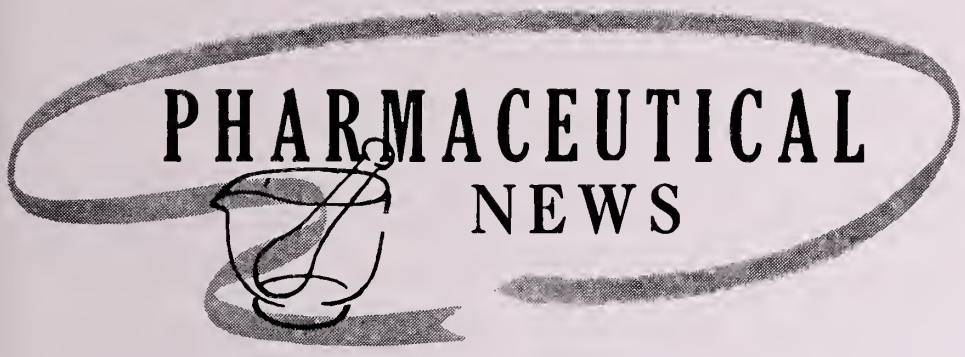
PROFESSIONAL TRANQUILITY

Professional tranquility is one of the chief occupational hazards of the pharmacist. This is a state of mind in which the pharmacist assures himself that as long as he pays the renewal fee for his license, he continues to be a competent practitioner of his profession and is fulfilling all his obligations for serving the health needs of his community. The danger of this type of thinking is the same whether the pharmacist works in a community pharmacy or a hospital pharmacy.

Self-complacency is acquired and maintained by completely ignoring or suppressing any thoughts that might occur about continuation of education. Since these thoughts usually are vague, uneasy feelings about a person's own ability or about his understanding of new advances in his profession, they are quickly dismissed. Many a pharmacist occasionally has a fleeting idea that it might be wise to do a little studying, read up on a new class of therapeutic agents, or even review pharmacology or medicinal chemistry; but more often than not, he finds various reasons for not acting upon such impulses. Examined under the strong light of truth, however, none of the excuses offered will hold up. The pharmacist who does not continually interest himself in new ideas, both in a professional concept and in a general sense, has succumbed to the habit of being professionally tranquilized and will soon sink into the rut of giving routine and mechanical service to his patrons. This rut is filled with quicksand, because he sinks deeper and deeper into it until he becomes buried in his work and loses all contact with progressive ideas.

Progressive ideas are the foundation on which each pharmacist must build his future. It must be recognized that anyone who considers his academic training as the complete basis for a professional career will be disappointed. Only by keeping abreast of current developments and by understanding technological advances can he establish himself as a professional person and achieve the success he desires.





BUREAU FOR THE ADVANCEMENT OF INDEPENDENT RETAILING SUCCEEDS BUREAU OF EDUCATION ON FAIR TRADE

A new name, replacing that of the Bureau of Education on Fair Trade has been announced by Willard B. Simmons, executive secretary of the National Association of Retail Druggists and chairman of BEFT and the new organization.

Succeeding BEFT is the Bureau for the Advancement of Independent Retailing, Mr. Simmons said.

The aims and purposes of the Bureau for the Advancement of Independent Retailing, Mr. Simmons said, are:

"To advance and promote the public welfare by encouraging and fostering independent retailing as a method of distribution based upon honest, economic and efficient service to the consumer;

"To gather and correlate information respecting independent retailing and its contributions to the public interest, including the interest of the American free enterprise system;

"To carry on education in the economic and social concepts implicit in independent retailing;

"To distribute publications and publicity of every kind, nature and description touching upon the values and contributions of independent retailing;

"To foster and encourage independent retailing by aiding in the improvement of its standards of service and of operation;

"To develop an understanding by the public and by government of the problems of independent retailing as a basis for lawful constructive actions, both public and private, that will contribute to the advancement of independent retailing."

Mr. Simmons said that the new Bureau will conduct an extensive program in the furtherance of its aims and purposes.

"We appreciate that there is very much we can ourselves do in the advancement of independent retailing. We also know Congress can help by enacting legislation that provides an atmosphere of fair competition in which the efficient independent retailer can compete, live and prosper."

Maurice Mermey, director of BEFT, is director of the Bureau for the Advancement of Independent Retailing.

FDA'S DIVISION OF NEW DRUGS REORGANIZED

Secretary Celebrezze has announced that he has approved a reorganization of the Division of New Drugs of the FDA's Bureau of Medicine. The new organization will permit FDA to discharge more effectively its increased responsibilities in the new drug area, the Secretary said.

An Investigational Drug Branch is being established to evaluate reports of proposed clinical tests of new drugs which manufacturers and others will submit in compliance with the investigational drug regulations. Frances O. Kelsey (M.D.) has been named Director of this Branch.

Earl L. Meyers (Ph.D.) will continue as Director of the Controls Evaluation Branch which evaluates the adequacy of laboratory and manufacturing controls proposed by manufacturers of new drugs.

The Medical Evaluation Branch will evaluate the medical safety and efficacy data in new drug applications. The Director is to be selected.

John F. Palmer (M.D.) will direct the New Drug Status Branch. This Branch will

consult with manufacturers and others about the application of the new drug section of the Federal Food, Drug and Cosmetic Act to chemicals newly proposed for drug use and to new uses or dosage schedules for drugs already on the market.

The New Drug Surveillance Branch will review inspectors' findings designed to reveal whether approved new drugs are being marketed in accordance with commitments contained in the new drug applications, and will evaluate reports of adverse reactions to new drugs which manufacturers must furnish FDA in accordance with the Drug Amendments of 1962. The Director is to be selected.

The five Branches will operate under the immediate supervision of Dr. Arthur Ruskin, recently appointed Deputy Director of the Division of New Drugs (presently Acting Director of the Division), and the general supervision of Dr. Ralph Smith, Director of the Division of New Drugs (presently Acting Director of the Bureau of Medicine).

Commissioner George P. Larrick said that the FDA is conducting an intensive recruitment program to obtain additional medical officers and other scientists to handle the greatly expanded technical workload of the Bureau of Medicine and other Bureaus of the FDA.

APhA ANNUAL MEETINGS SCHEDULED THROUGH 1965

The annual meetings of the American Pharmaceutical Association have been scheduled through 1965.

The Americana in Bal Harbour, Miami Beach, Florida, will host the 1963 annual APhA meeting the week of May 12-17.

Philadelphia was selected as the site for the 1964 annual meeting with the Sheraton and the Bellevue-Stratford hotels as co-headquarters. The 1964 annual meeting is scheduled for the week of May 3-8, so that members attending the APhA annual meeting will also be able to visit the New York World's Fair opening the previous week.

Detroit has been selected as the site for the 1965 annual meeting for the week of March 28 - April 2. All meetings and exhibits will be held at Cobo Hall.

NEWS IN BRIEF FROM AROUND THE STATE

Floyd Tabor, prominent Madison pharmacist, died on January 2nd, at the age of 73. He is survived by his widow and two sons. Interment was made at Garretson.

Mr. and Mrs. A. O. Bittner, Aberdeen, are spending the winter months with their daughter at Shiprock, New Mexico.

Francis Steinwand, Mobridge, is the new pharmacist at the Spiers Pharmacy, Milbank. He relieves Kenneth Ryan who is presently taking a trip to Arizona and California.

Vernon Olson, Huron, has accepted a position at Watertown, Minnesota. William Hoel, Fargo, is the new pharmacist at Humphrey Drug, Huron.

Richard Assam has opened a new pharmacy at Lake Andes in a building owned by Mrs. Danks, widow of a former Lake Andes pharmacist.

August Worth, former pharmacist at Pukwana, died at Garretson in November.

T. K. Haggar, Watertown, underwent surgery late last year at Rochester.

Mr. and Mrs. Ted Hustead, Wall, had their annual checkup at Rochester.

Voy Drug, Dell Rapids, has installed new fixtures. The store is under the management of Don Entwistle.

Mr. and Mrs. Mort Lauer, Kreiser Drug, Watertown, attended the Rexall Convention in California.

Mr. and Mrs. Vere Larsen, Alcester, and Mr. and Mrs. G. A. Thoreson, Beresford, attended the inaugural ceremonies at Pierre.

Harry Lee, Alcester, was in Washington, California and Mexico over the Holidays. He attended the Rose Parade on New Year's day.

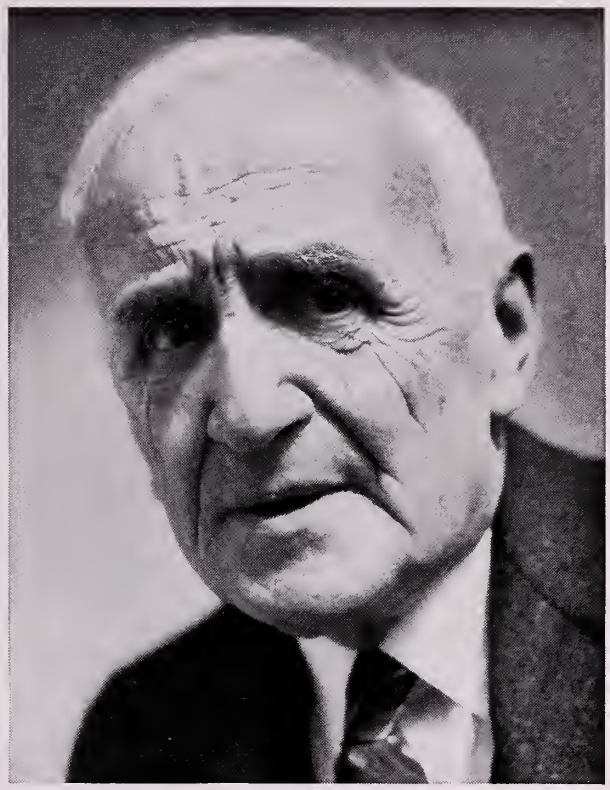
Myron Weber has opened a second store at Wessington Springs.

Larry Wright has purchased the Robinsdale pharmacy at Rapid City from George Tibbs and Joe Goldman. The pharmacy is now called Wright's Robinsdale Drug.

Enrollment in the Division of Pharmacy, South Dakota State College, for the winter quarter is 205. There are 48 pharmacy seniors.

The State Board of Pharmacy met in Brookings on January 8 and 9 to conduct examinations for licensure. Written and oral examinations were given to eight applicants; one reciprocity examination was given.





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METAMUCIL®

adds tone to the atonic colon

Metamucil, refined hydrophilic mucilloid, is especially suited to correct the kind of constipation most frequently encountered in elderly patients.

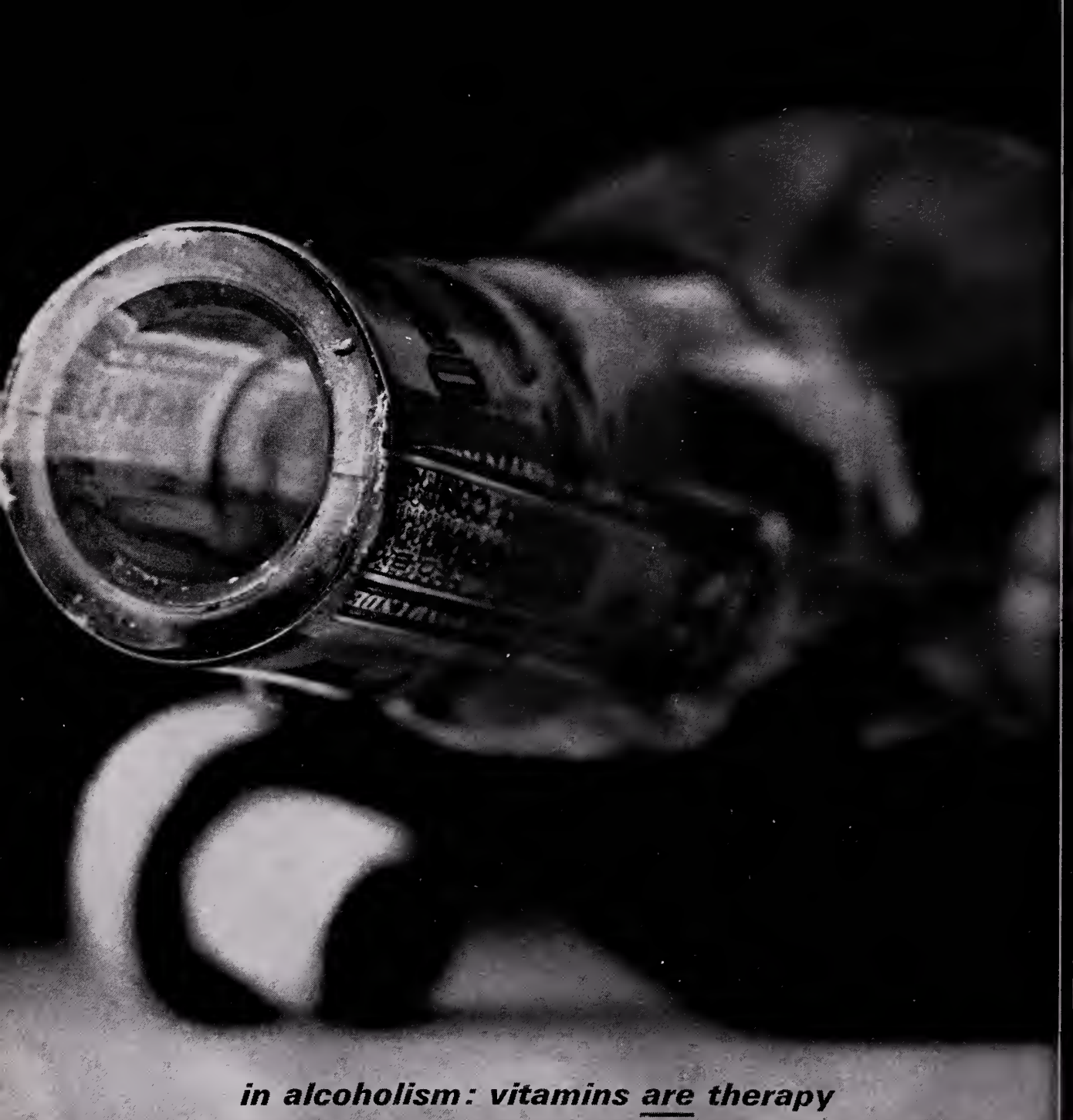
Metamucil adds soft bulk to the often inadequate diets of older persons and supplies the gentle intracolonic pressure needed to induce normal peristaltic action.

This true physiologic stimulus increases muscle tone, encourages normal reflex activity and helps reestablish the natural rhythmic function of the bowel. Only a soft bulk stimulus like Metamucil offers such natural encouragement to normal evacuation.

Metamucil is available as Metamucil powder in 4, 8 and 16 oz. containers and as lemon-flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

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Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

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prompt 4 way check of diarrhea

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EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P. ...	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P. ...	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

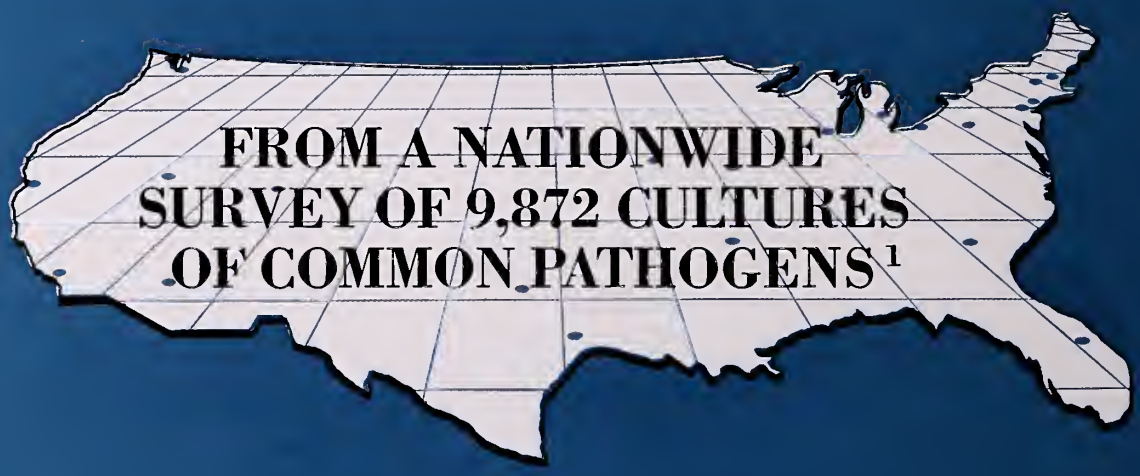
Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

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Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.



SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

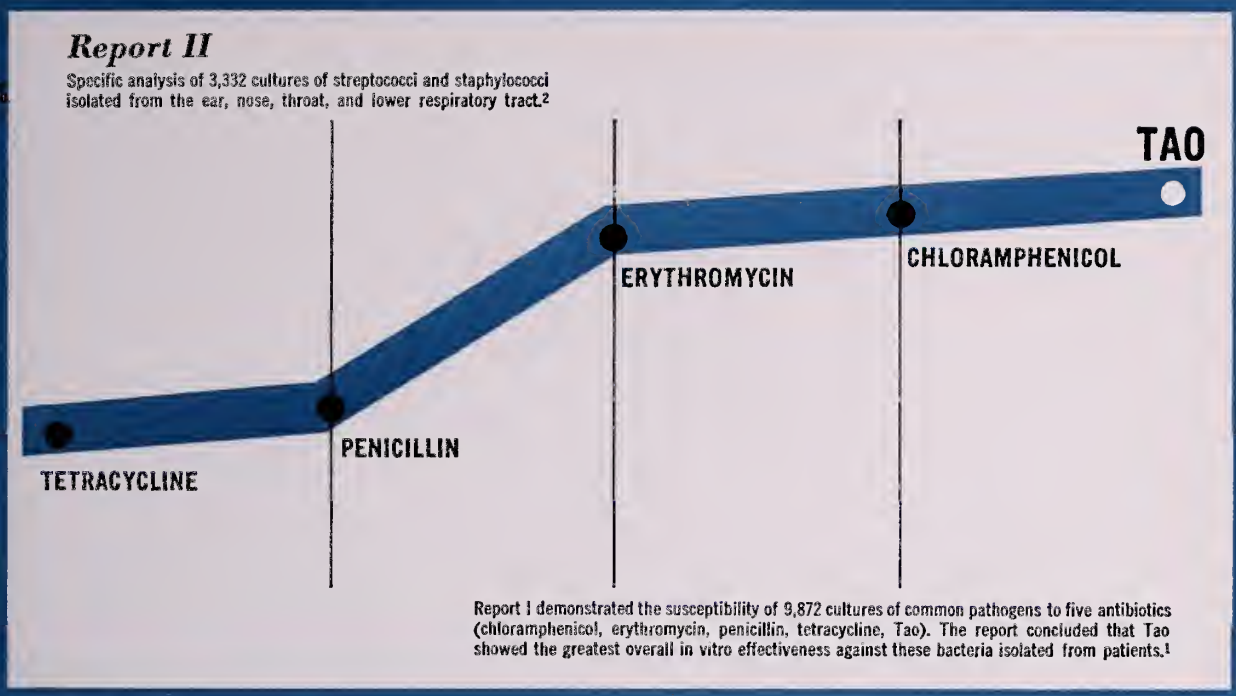


Conclusions of Nationwide Survey: *Report I*

1. **Even after five years of general use,** Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. **Overall results showed a higher percentage of susceptibility** among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. **Tao has been used for five years without development of predictable cross resistance.** In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

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VIGOR

Behind the success of Blue Shield has been the continuing urge to increase its value to the public. This is to be applauded, but it cannot be considered a basis for relaxation of effort. As one doctor said: "There is need for us to remind ourselves constantly that we have not reached the ultimate in benefits or enrollment, although the Utopia promised by some is not our expectation."

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the bronchodilator
with the intermediate dose of KI

A combination of the four most widely used drugs for the treatment of asthma. Each Mudrane tablet contains Potassium Iodide 3 grains, Aminophylline 2 grains, Ephedrine HCl ¼ grain, Phenobarbital ⅓ grain . . . compounded for prompt absorption and balanced action, and buffered for tolerance.

Dispensed in bottles of 100 and 1000 tablets

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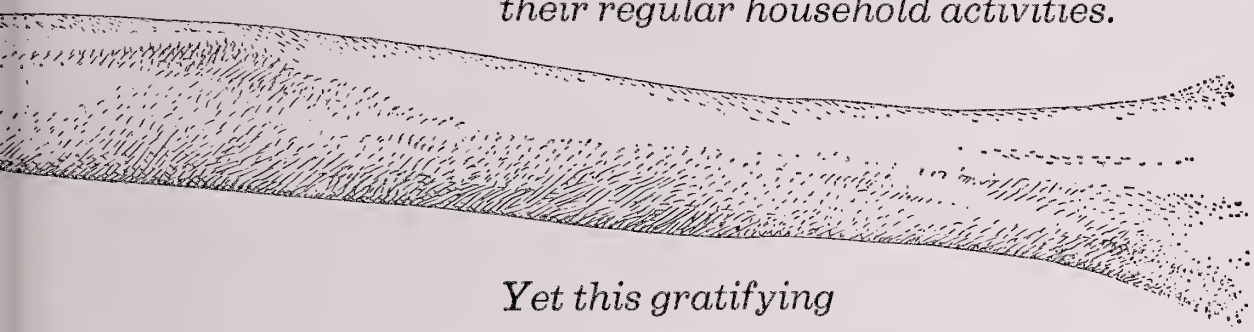
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inful joints

With ARISTOCORT, *patients with painful, arthritic joints obtain rapid reduction of pain and inflammation, as well as substantial improvement in joint mobility. Many patients who might otherwise be confined in a state of invalidism have been able —with* ARISTOCORT—*to continue their customary livelihoods or go about their regular household activities.*



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SUPPLIED: Scored tablets (three strengths), syrup, parenteral and various topical forms. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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In each persian-rose enteric-coated tablet: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

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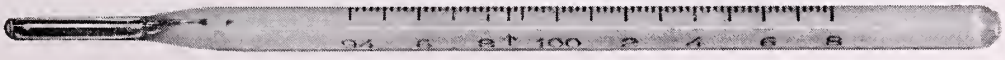
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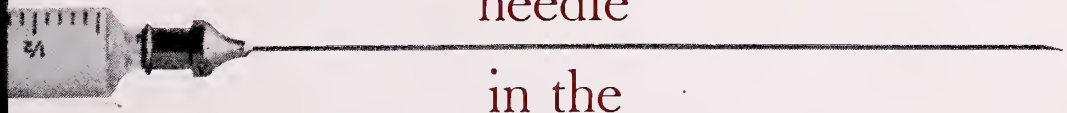
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JOURNAL OF THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION,
THE SOUTH DAKOTA PHARMACEUTICAL ASSOCIATION AND
THE SIOUX VALLEY MEDICAL ASSOCIATION

Volume XVI **March, 1963** **Number 3**

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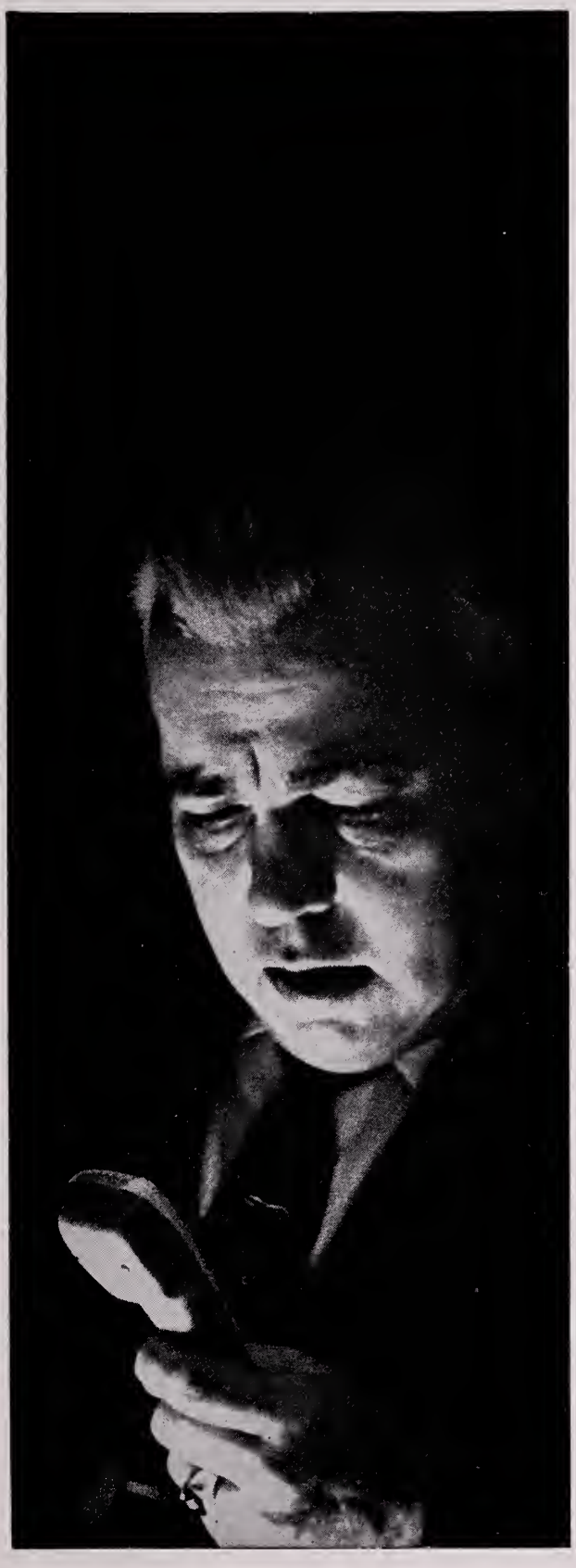
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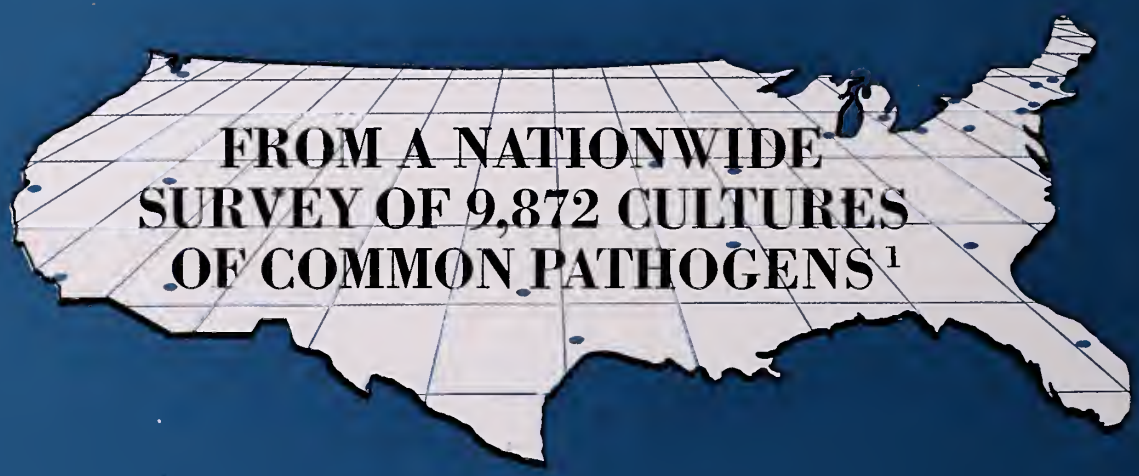
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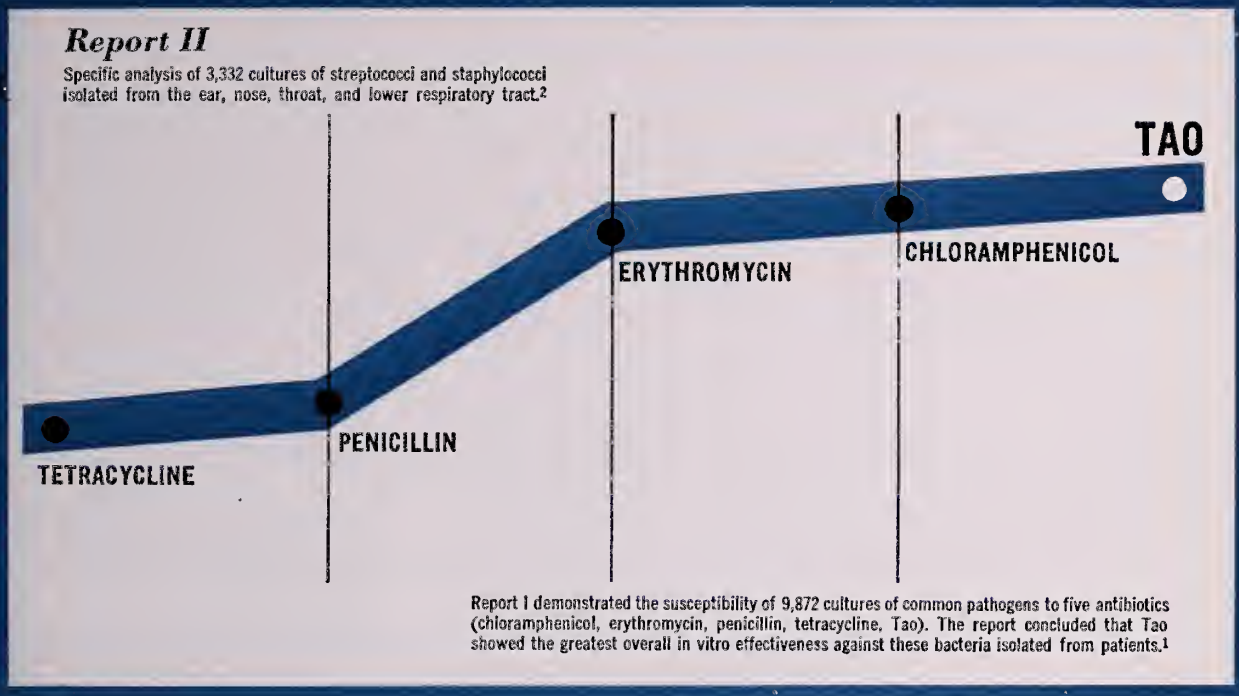
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Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

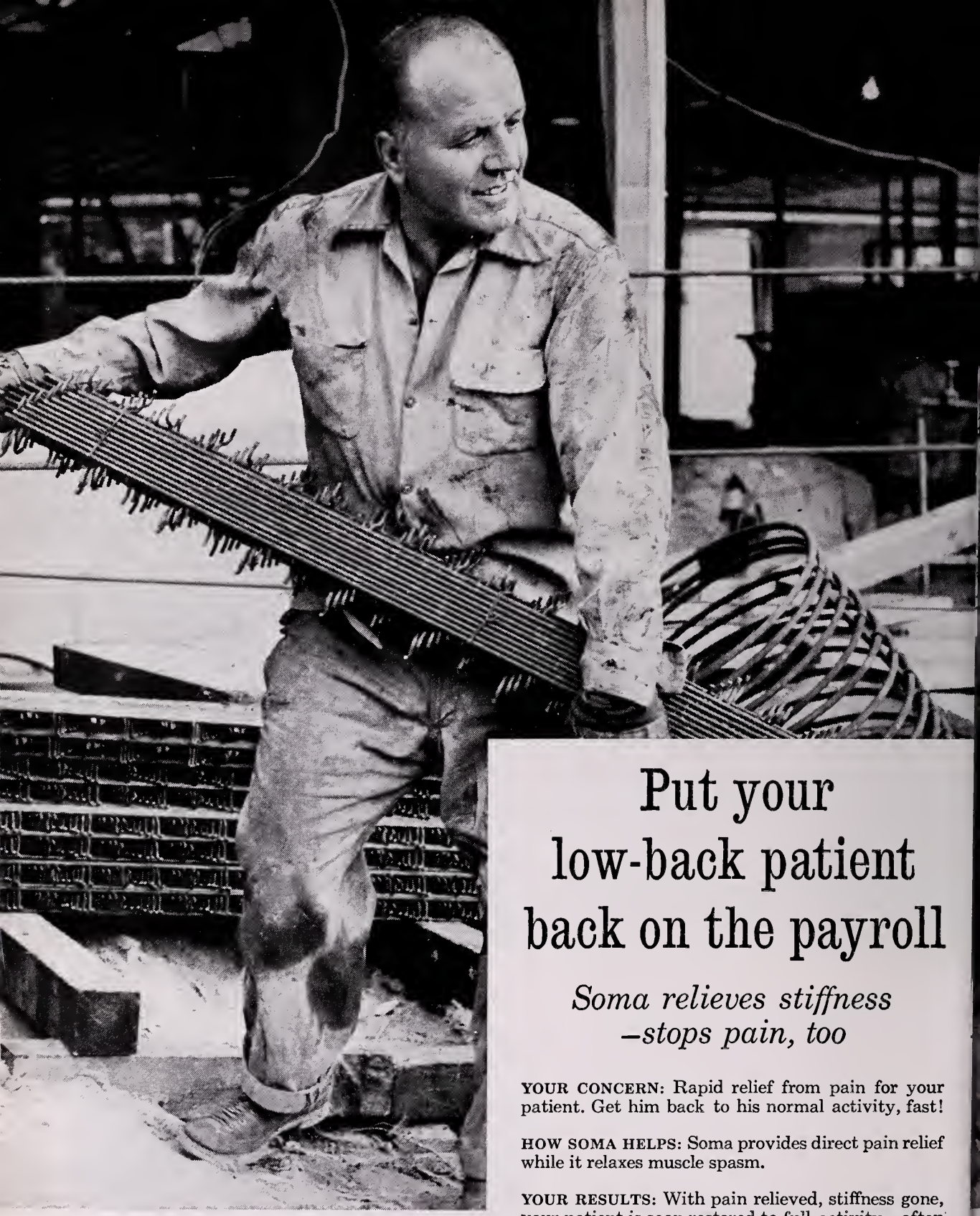
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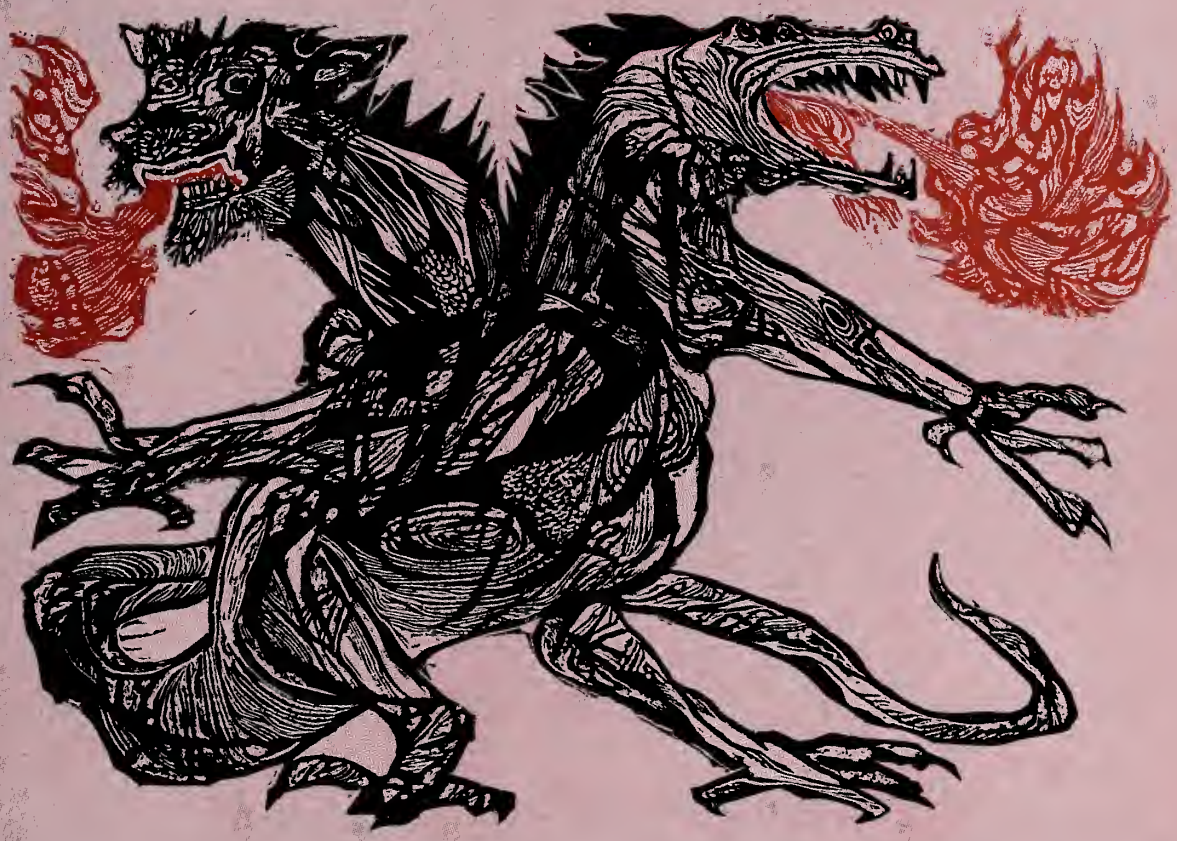
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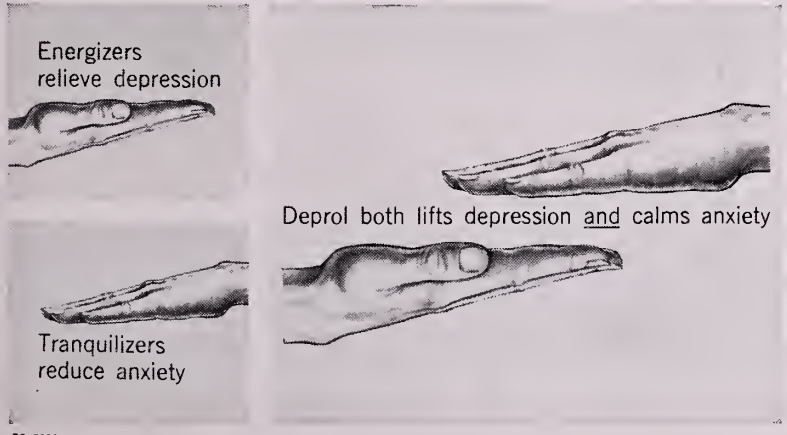
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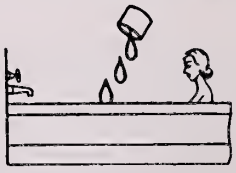
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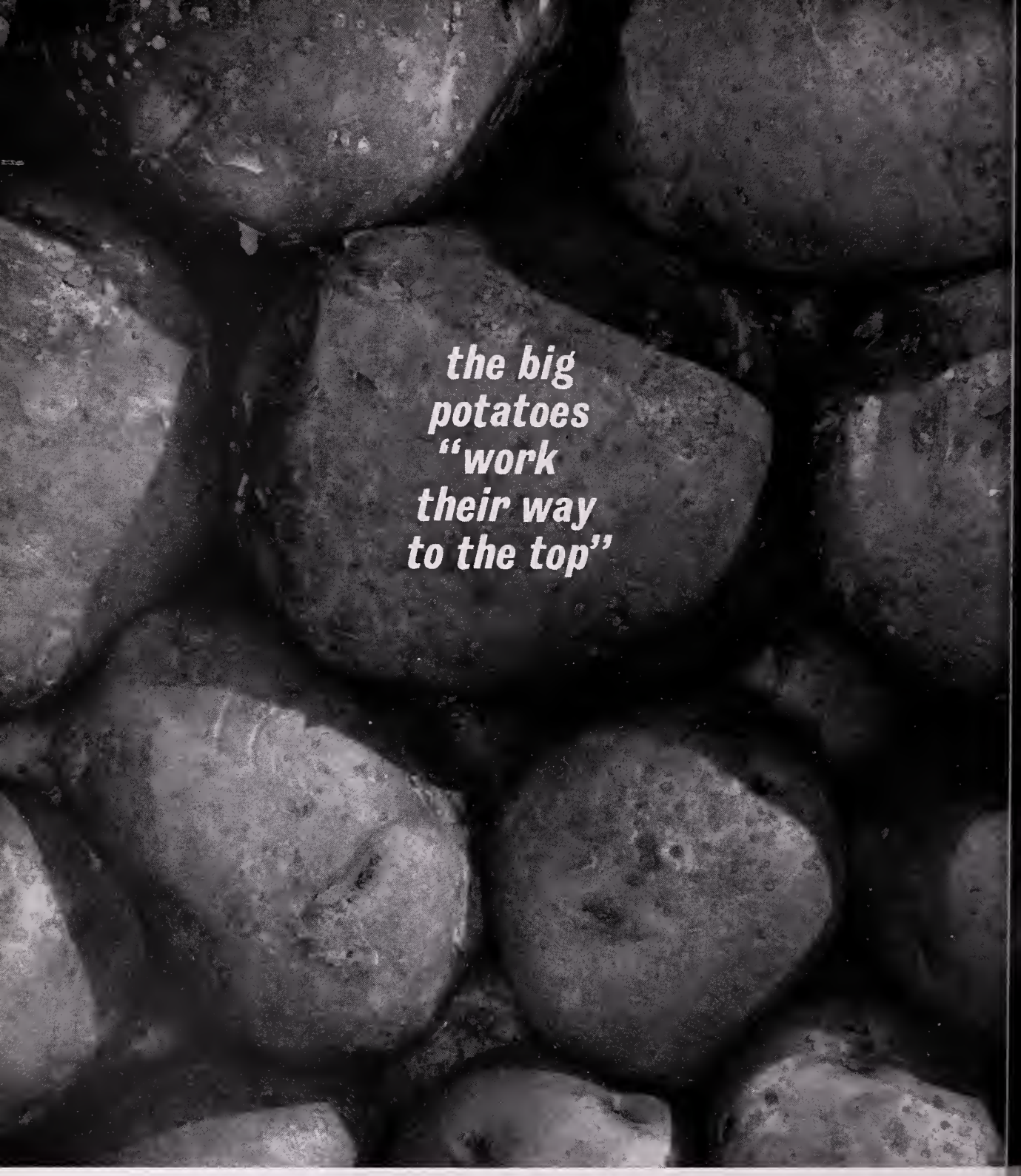
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Scientific PAPER

Acute Pancreatitis in Childhood

by

E. H. Heinrichs, M.D.* and D. N. Fedt, M.D.

Watertown, South Dakota

Acute pancreatitis as a cause of an acute abdomen in a child is an extreme rarity. Most cases described in the literature are only isolated case reports. DOBROTVORSKY[7] in 1912 reported the first case of pancreatitis in a child after trauma. PHELIP[17] in 1920 presented the first idiopathic pancreatitis in a child, and the first description in the American literature appeared in 1923 by ANDERSON.[1] Since then the reports have been more frequent. The latest summary of the world literature on this subject[3] as of 1961 lists 74 cases of pancreatitis in children. Since then seven more cases have been reported.[16, 18, 19, 20] This presentation will add another.

CASE REPORT

This 8-10/12 year-old white female was well until 24 hours before admission when she started vomiting bile-stained material and later had some pain in the epigastrium. Thereafter she drank only carbonated beverages, but the vomiting continued. No temperature elevation was noted. Because there was no change in her condition after 24 hours, she was seen in the office with signs of an acute abdomen and moderate dehydration. The leukocyte count measured 19.450 per cubic millimeter with a shift to the left, the hemoglobin was 16.5 grams per 100 cubic centimeter, the microhematocrit was 50 volume percent. She was immediately admitted to the Watertown Memorial Hospital.

Past History: Apart from occasional upper respiratory infections, a tonsillectomy and adenoidectomy at the age of five years, the past history was negative.

* Pediatric Department, Bartron Clinic, Watertown, South Dakota.

Family History: The parents and one brother are living and well, another brother is allergic.

Physical examination on admission: Temperature 101° Fahrenheit. (38.3° Centigrade), rectally. Blood pressure 170 millimeter mercury systolic, 75 millimeter mercury diastolic. Pulse 144 per minute. Respiratory rate 24 per minute.

This slightly obese (30 Kilograms) white female was acutely sick; moderately dehydrated, had a flushed face and was apprehensive. The abnormal findings were confined to the abdomen with generalized tenderness and involuntary guard present, but more pronounced in the umbilical region. Rebound phenomenon was elicited, no organs or masses felt. Bowel sounds were absent with moderate general distension of the abdomen; questionable fluid waves, but no shifting dullness and no radiation of pains. No scars, hernias or lymph nodes were present. The rectal examination was negative.

Laboratory values four hours after admission: The leukocyte count had risen to 24.200 per cubic millimeter. The urine analysis, after intravenous fluids had been started, showed albumen: ++, sugar: trace, and on microscopic examination of the sediment 8 - 10 leukocytes per high powered field.

Roentgenological Findings: Roentgenogram of the chest: Negative. A flat and upright film of the abdomen: Air in the small bowel. Barium enema as far as the ascending colon: Negative.

IMPRESSION: Inflammatory disease within the abdomen.

Admission Diagnosis: Acute abdomen with moderate dehydration. The following conditions were considered:

(1) Upper gastrointestinal obstruction; such as, volvulus just below the ligament of Treitz.

(2) Perforated viscus; such as perforated appendicitis, perforated Meckel's diverticulum or perforated posterior duodenal ulcer.

(3) Acute pancreatitis.

Course in the hospital: It was the impression at the time that the acute abdomen was most likely caused by an appendicitis and that an exploratory laparotomy should be done. This was carried out (D.N.F.) through a lower right rectus incision. Upon entering the peritoneal cavity a rather profuse amount of grayish thin exudate was noted. The bowel seemed distended and the omentum showed scattered white plaques 2 - 3 millimeters in size, resembling necrosis. The omental tissue was friable. The exploration was carried out after removal of peritoneal fluid. The appendix contained several fecaliths but showed no signs of acute inflammation. A Meckel's diverticulum was found, not inflamed. The pancreas was edematous, swollen. A piece of omentum was taken for pathological examination. The wound was closed in typical fashion. The immediate postoperative course was uneventful.

> Amylase of the peritoneal fluid: 780 Somogyi units. Bacterial culture of the peritoneal fluid: Negative. Pathological diagnosis of the omentum: Fatty degeneration of omental tissue.

The patient was placed on nothing by mouth, continuous intravenous fluids, continuous nasogastric suction, intermittent rectal tubes, tetracycline intravenously, atropine intramuscular, Meperidine hydrochloride if necessary for pain.

During the first eight days postoperatively the patient improved very slowly. A mild temperature elevation persisted throughout the first week. She started having a few bowel sounds on the second day postoperatively, but at the same time developed a hypostatic pneumonia bilaterally, for which she was treated with intramuscular penicillin and streptomycin. The fluid intake-and-output and the serumelectrolytes were always in balance, except for low potassium values, despite potassium given intravenously. The serumamylase was 627 Somogyi units on the first day and 165 Somogyi units on the third day postoperatively. (Normal: 60 - 160 Somogyi units). The serum calcium was 8.6 milligrams per 100 cubic centimeter serum (4.3 milliequivalents per liter serum) on the third day postoperatively. Calcium gluconate was given intravenously in high dilutions, but still resulted in a thrombophlebitis of the leg

veins. On the sixth day postoperatively the bowel sounds had improved so that the intravenous fluids were discontinued and oral feedings could be started. Thereafter the patient progressed without further complications and could be discharged on the twelfth day of hospitalization.

Since discharge eight months ago, the child has been asymptomatic except for some upper abdominal discomfort after meals on two occasions, which were of short duration. It was thought that these did not represent attacks of chronic pancreatitis.

DISCUSSION

Clinical features and diagnosis: The symptomatology has been extensively investigated by STICKLER and YONEMOTO[22] and there seems to be some difference as compared to the adult group which may easily lead to erroneous diagnosis in a child.

Typical is the very sudden onset of pain, but the localization of pain occurs only in one-third of the patients in the epigastrium. More likely are generalized abdominal or even lower abdominal pains, which are rarely radiating. Local tenderness, voluntary resistance and spasm of the abdominal muscles are rather insignificant. The Gray-Turners sign — a blue discoloration around the umbilicus and/or in the flanks — is rare. Vomiting is a common complaint. Shock is only present in one-half of the patients, the fever is moderate, the bowel sounds are most likely present, abdominal distension is frequent.

The laboratory findings show elevated white blood counts in only half of the cases and are seldom helpful. The elevated serumamylase is definitely diagnostic. The findings on surgery are typical, showing mesenteric fat necrosis and free "beef-broth" fluid in the peritoneal cavity, along with an enlarged, swollen hemorrhagic pancreas. Only a high degree of suspicion in a child with an acute abdomen will lead to investigation of the serumamylase level, which is very helpful in a case of pancreatitis. But if one is dealing with a posterior perforation of a duodenal ulcer into the pancreas one would find the same symptomatology and laboratory values. Other conditions that are known to elevate the serumamylase are mumps, uremia, administration of codeine and morphine, presumably due to spasm of the sphincter of Oddi, and subsequent retention of pancreatic secretions.[24]

By way of differential diagnosis one must consider the more common etiological factors of an acute abdomen in a child: acute appendicitis, mesenteric lymphadenitis, peritonitis, perforated viscus, acute intestinal obstruction and unrecognized trauma, some of them can even cause pancreatic involvement with elevated serumamylase.

Pancreatitis has been observed at any age; it seems to occur even in utero, since one child, which lived only for one minute, showed acute pancreatitis extending from an intrauterine peritonitis.[3] It also occurs approximately twice as frequently in females as in males.[22]

Pathology and Etiology:

The pancreatitis appears clinically in two distinct forms: the acute and the chronic pancreatitis. Pathologically the acute fulminating hemorrhagic pancreatitis or pancreatic necrosis is usually accompanied by bloodstained "beef-broth" peritoneal fluid and fat necrosis of the pancreas, omentum, appendices epiploicae, mesentery and subcutaneous fat tissue. The pancreas is usually a hemorrhagic necrotic mass in which identification of structures is impossible. The clinically milder forms of focal pancreatitis or focal pancreas necrosis are a subgroup of the acute pancreatitis.

The interstitial pancreatitis or mild edematous pancreatitis shows only edema of the pancreas and a glistening tense capsule with microscopic evidence of pancreatitis in the interstitium.

BLUMENTHAL[3] has divided the etiology of acute pancreatitis in children into several subgroups. The tabulation used here with minor changes is based on his work and lists all known etiological factors of the acute pancreatitis in childhood.

(1) Pancreatitis associated with or after infections:

Tonsillitis, otitis media, bronchopneumonia (after burns), bacteremia (with meningitis or leukemia) and/or with septic embolism to the pancreas, peritonitis, mesenteric lymphaden-

itis, infectious hepatitis, neonatal syphilis, (mumps), measles, rubella, roseola, infectious mononucleosis, cytomegalic inclusion body disease, virus infections (especially Newcastle and Coxsackie B), chickenpox.[19]

(2) Pancreatitis associated with pancreatic or biliary ductal abnormality or obstruction:
Ascariasis, gallstones, secondary perforation of the common bile duct.

(3) Pancreatitis associated with metabolic, toxic or chemical factors:
Cirrhosis of the liver, diabetic coma, anoxia, kwashiorkor, cortisone therapy.

(4) Pancreatitis associated with trauma:
With or without formation of pseudocysts, trichobezoar, following operations (multiple congenital atresia of the ileum).

(5) Pancreatitis due to unknown cause.

As one can see from this tabulation the etiology of pancreatitis in childhood differs from the disease in adulthood, where alcoholism, vascular accidents, gallstones and other obstructions of the pancreatic duct are the most important etiological factors.[9] In contrast, in the pediatric age group the cause remains unknown or can only be suspected in most of the patients.

Pancreatitis is known to occur associated with infections, either directly due to septic embolism to the pancreas, bacteremia and mesenteric lymphadenitis[20] or secondary due to infections ascending from the duodenum into Wirsung's duct, especially in individuals which are bedridden over extended periods of time for other diseases, have gastroenteritis, or are cachectic. Mumps is frequently accused of causing acute pancreatitis but this is difficult to establish since elevations of serumamylase occur also with inflammation of salivary glands.[23] On the other side pancreatitis with mumps is rarely hemorrhagic, its course is mild and pathologically more of the interstitial type. Also, with the widespread of mumps infections, one would expect to see the acute hemorrhagic type more frequently. In the pediatric age group, so far, no pancreatitis has been reported following such infections as typhoid fever, Weil's disease, scarlet fever and malaria, which are known to be the cause of acute pancreatitis in the adult, but one has to consider the possibility of pancreas involvement as complications of these diseases.

Pancreatitis associated with abnormalities and/or obstruction of the common bile duct, Wirsung's duct or Vater's papilla can cause a backing-up of pancreatic juice into the pancreas, where it becomes activated. At least in one child this had been the cause for repeated bouts of acute pancreatitis.[2] Gallstones and ascaris-worms have been found as an obstructing agent.[8, 10, 11, 12, 15]

Pancreatitis associated with metabolic, toxic or chemical factors plays an important part in the pediatric age group, but here one cannot frequently trace the cause of pancreatitis back to the original disease, rather more often to secondary causes, similar to infections. This is specifically true for diabetic coma (STEINER, cited by[3]), liver cirrhosis[1] and kwashiorkor.[5] Long term cortisone therapy for nephrosis and leukemia has caused acute pancreatitis in several instances,[16] but the majority show only focal inflammation and necrosis. Hyperparathyroidism as a cause or complication of acute pancreatitis in childhood, as reported in adults,[14] is not known. Pancreatitis associated with trauma has resulted in many reports[7] (as well as many more) and does not seem to differ from similar lesions in the adult group. A bizarre case report lists a trichobezoar as the cause or complication of a pancreatitis.[2]

The idiopathic pancreatitis (pancreatitis due to unknown cause) is probably the largest etiological group of them all and it was thought that the case presented in this report belonged in this group. A theoretical and experimental explanation of this disease has been given in 1954 on the basis of anaphylactic phenomenons, as the local Shwartzman-Sanarelli reaction.[13, 23]

TREATMENT AND PROGNOSIS

The fulminating hemorrhagic pancreatitis is a serious illness, the interstitial edematous pancreatitis has an excellent prognosis. With the advanced knowledge of fluid and electrolyte problems during the last two decades, only very few children succumb to an attack of acute pancreatitis. The treatment should

be conservative with strict bedrest, parenteral fluids, nasogastric suction, sedation, antibiotics and anticholinergic drugs. There are reports that hydrocortisone in animals increases the survival rate in acute hemorrhagic pancreatitis.[6] This has been used therapeutically in adults[4] but in view of the fact that cortisone itself can cause pancreatitis, its use appears not advisable at the present time, unless more data are collected.

Surgery is not necessary, unless one cannot exclude with certainty an appendicitis or perforated viscus. It seems from the reported cases that an exploratory laparotomy has no deleterious effect on the outcome if combined with a conscientiously administered intravenous fluid program.[22] The removal of a large amount of activated pancreatic juice from the abdominal cavity may even be beneficial. Surgery becomes mandatory when complications arise such as pancreatic pseudocysts, abscess formation or hemorrhage from the celiac axis.[18]

Complications are sometimes a temporary hyperglycemia requiring insulin and a hypocalcemic tetany (usually on the third day) requiring Calcium gluconate.

After recovery the patient may experience recurrent bouts of chronic pancreatitis manifested by vomiting, diarrhea and upper abdominal discomfort and pain, which definitely should be treated conservatively. Serumamylase values remain normal during these attacks.

SUMMARY

A case of acute hemorrhagic pancreatitis in an 8-year old child is presented. The clinical symptomatology and diagnosis, the pathology and etiological factors, and the prognosis and treatment are briefly discussed.

The acute hemorrhagic pancreatitis represents a rare cause of the acute abdomen in childhood.

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Wanted: Physician or Surgeon at Bottineau, North Dakota. Write to Sigurdson Drug or Sigurd Sigurdson, Bottineau, North Dakota.



SOCIETAS MUNDI MEDICA

By

Richard L. Lillard, M.D.

Winner, South Dakota

The hasty and cryptic telegram read: "REQUEST IMMEDIATE AIR LIFTING OF ANTIPYRETIC ANALGESICS AND IF AVAILABLE POLYVALENT FLU VACCINE." Influenza was raging through the Philippine Islands, and the supplies of the doctors were exhausted. The time: the beginning of the Memorial Day weekend, 1957. The Philippine Medical Association sent this message to the office of the Secretary General of the World Medical Association in New York.

Even though the offices of the World Medical Association were closing, as were most offices throughout our country — due to the long weekend ahead — the Secretary General and his staff began immediately to work on accomplishing the objective. The Civil Aeronautics Board was notified of the emergency, and it began untying the red tape of international transport. Drug manufacturers were contacted and asked for donations. Employees were called back to work. Burroughs-Wellcome Company prepared an immediate 300 pound shipment, and Flying Tiger Airline flew the shipment to San Francisco where a Pan American Airliner waited to transport it to the Philippines. In a few hours other companies helped with voluntary spontaneity. McNeil Laboratories, Pfizer and Squibb prepared shipments of hundreds of pounds of supplies. Eli Lilly and Company launched a "crash" program as a weekend project in sending the much-needed influenza vaccine from Indianapolis.

Speaking of the splendid accomplishment of the pharmaceutical firms which par-

ticipated, Dr. Louis Bauer, former Secretary-General of the World Medical Association, noted: "It is in the unity of purpose in such emergencies that the strength of the members of the health professions is tested and proved equal to the task. It gives and does not count the cost; it toils without resting; and asks no reward for its labor than a better and happier world for all people."

This, then, is the World Medical Association at work. Its emblem is recognized throughout the free world as a picture of the Globe on which is imposed the Staff of Aesculapius, and at the superior periphery of which are the words SOCIETAS MUNDI MEDICA, the Latin being used to signify its universality.

Many of you will be surprised to know that you are members of the World Medical Association. By virtue of your membership in the American Medical Association, which donates a small fee for each of its members, you are a member of the International Voice of Organized Medicine. Since few of us are familiar with the aims and accomplishments of this organization, it will be the purpose of this paper to extol its various facets.

HISTORY AND ORGANIZATION

The World Medical Association was formed in 1947, and is a global, non-governmental establishment composed of Member-Nations.

It was first considered a possibility when doctors of all the Allied Nations during World War II would meet at the House of the British Medical Association. "Bull-sessions" invariably resulted from the companionship engendered by like interests. As a direct result of these informal meetings, the British Medical Association called a meeting to consider initiation of an International medical organization. Twenty-nine National Medical Associations sent representatives to this "Conference of Delegates" in the fall of 1947. Out of this Conference came a Constitution and By-Laws, it being decided that each member-nation would have equal voting power, regardless of numerical strength.

The Member-Nations are represented by the recognized organization which speaks for the majority of the physicians in the particular country. Only through his membership in this organization does the individual gain membership in the World Medical Association. You and I are, therefore, members of the World Medical Association by reason of our membership in the American Medical Association.

However, individual memberships are available in the "Committee" which represents each country to the World Medical Association. In our country, the "United States Committee" represents its members, who actively encourage the work of the World Medical Association in the United States and abroad. The United States Committee is to the World Medical Association what your State Medical Association is to the American Medical Association, by way of comparison. In joining the American Medical Association, you have passively become a member of the World Medical Association. But, to become an actively functioning member, you may join the United States Committee. This structure allows the Association to be an International Voice with definite aims, accomplishments and benefits.

The Headquarters Secretariat and the office of the Secretary-General are located in New York City. The present officers of the World Medical Association are:

Dr. R. V. Sathe, President-Elect
Bombay, India
Dr. Harry Gear, Secretary-General
New York City
Dr. Gunnar Gunderson, Chairman of Council
LaCrosse, Wisconsin
Dr. Ernst Fromm, Treasurer
Hamburg, Germany
Dr. Antonio Moniz de Aragao, President
Florianopolis, Brazil

By tradition, the President-Elect has been from the country in which the next Annual General Assembly will be held. He is prominent in his national Medical Association as well as actively engaged in Medicine.

Today, the World Medical Association has 57 Member-Nations and about 750,000 members. The U. S. Committee has just over 5,000 members.

This representative cross-section of the Medical Associations of the world is well suited to speak for differing cultures, mores and religions, in order to accomplish harmoniously the aims of its constitution.

PURPOSES

The major objectives of the World Medical Association are:

1. To protect and promote the freedoms essential to the most effective practice of

medicine.
2. To raise the standards of Medical Education and health throughout the world.
3. To bring together physicians from all over the globe for the sharing of knowledge and ideas.
4. To provide a world forum for discussion and solution of problems common to Medicine the world over.
5. To speak for the physician before other world organizations concerning health or medical care.

ACCOMPLISHMENTS

To consider an organization worthy of your time and support, you like to know what it has achieved.

One of the first goals of the Association was the establishment of the **WORLD MEDICAL JOURNAL,** a bi-monthly publication which is truly universal in that its articles are each presented in three languages: English, French and Spanish. It is the only medical journal developed as a world-wide medium. In this Journal you read of the problems of Medicine in Member-Nations, and what solutions have been advanced. You also learn of the varied medical thought of other environments, of the heroic efforts by practitioners in various parts of the globe, and of the dignity of man in search of truth.

A second accomplishment of the Association has been the two World Conferences on Medical Education: the first in London in 1953, and the second in Chicago in 1959.

Perhaps more important than any recent action is the activity in the field of Ethics. It has supported and promulgated the "Declaration of Geneva," a modified Hippocratic Oath, and it has supported an International Code of Medical Ethics. So important are these two documents in the philosophy of this organization, they are reprinted in Illustration 1. At present, the World Medical Association is intimately concerned in regulations governing Human Experimentation, the need for which has recently been made clear by the drug-induced fetal-malformation-tragedy of Europe.

Probably the best known achievement of the World Medical Association is the Central Repository for Medical Records, in which every physician may deposit for safekeeping his educational and professional credentials. It is a fact that many hundreds of physicians are today serving as nurses, orderlies, technicians and laborers because they have no way of proving that they ever attended a medical school. They are the real displaced personalities of our day — the victims of the chaos and heartbreak wrought by a paperhanger who almost won the world with Panzer divisions, the Luftwaffe and Storm Troops, while good men did nothing to stop him. In order to prevent a recurrence of this tragic loss of records, the World Medical Association established its Central Repository where certified copies of Medical credentials are accompanied by documents of identification. In this way, a physician's credentials cannot be destroyed by World War or Hungarian Uprising or by a Cuban disaster, to name a few from the recent past, which have caused irreplaceable losses to men of our profession.

The World Medical Association promotes international exchange of medical students and teachers, is improving standards of Medical Practice and Public Health and is being gradually successful in removing trade restrictions and arbitrary licensing requirements in order to promote the free flow of proven therapeutic agents.

Opposition to governmental controls is a major concern of the World Medical Association. It does have Member-Nations which are partially or completely socialized, for example Great Britain, Canada, and Australia. But it has accomplished a good deal in preventing socialization in other nations. An excellent example is Malta, where the Territorial Government tried threat, insult and harassment to establish salaried rather than private practice. The 200 physicians on Malta resisted and the Prime Minister hinted that he would import physicians to carry out his plan. On hearing of this, the World Medical Association alerted all neighboring countries and the plan was overcome due to the helpful attitude and solidarity of the World's physicians, who thus demonstrated that such solidarity can prevent pressure being used to accomplish governmental control of Medicine. It is a lesson for all of us. The World Medical Association has recently helped or is helping in similar incidents in Venezuela, Chile and Japan, with excellent results to date.

A project which is receiving attention at

International Code of Medical Ethics

Adopted by the Third General Assembly of THE WORLD MEDICAL ASSOCIATION, *London, England, October 1949*

DUTIES OF DOCTORS IN GENERAL

A Doctor Must always maintain the highest standards of professional conduct.

A Doctor Must practice his profession uninfluenced by motives of profit.

The Following Practices are deemed unethical:

a) Any self advertisement except such as is expressly authorized by the national code of medical ethics.

b) Collaborate in any form of medical service in which the doctor does not have professional independence.

c) Receiving any money in connection with services rendered to a patient other than a proper professional fee, even with the knowledge of the patient.

Any Act, or Advice which could weaken physical or mental resistance of a human being may be used only in his interest.

A Doctor Is Advised to use great caution in divulging discoveries or new techniques of treatment.

A Doctor Should certify or testify only to that which he has personally verified.

DUTIES OF DOCTORS TO THE SICK

A Doctor Must Always bear in mind the obligation of preserving human life.

A Doctor Owes to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity he should summon another doctor who has the necessary ability.

A Doctor Shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him.

A Doctor Must give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

DUTIES OF DOCTORS TO EACH OTHER

A Doctor Ought to behave to his colleagues as he would have them behave to him.

A Doctor Must Not entice patients from his colleagues.

A Doctor Must Observe the principles of "The Declaration of Geneva" approved by The World Medical Association.

Declaration of Geneva

Adopted by the General Assembly of THE WORLD MEDICAL ASSOCIATION *at Geneva, Switzerland, September, 1948*

At the Time of Being Admitted as a
Member of the Medical Profession:

I Solemnly Pledge myself to consecrate my life to the service of humanity.

I Will Give to my teachers the respect and gratitude which is their due;

I Will Practice my profession with conscience and dignity;

The Health of My Patient will be my first consideration;

I Will Respect the secrets which are confided in me;

I Will Maintain by all the means in my power, the honor and the noble traditions of the medical profession;

My Colleagues will be my brothers;

I Will Not Permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I Will Maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I Make These Promises solemnly, freely and upon my honor.

Text as correlated with other official language texts—April 1956.

(Illustration 1)

present is an emblem for Civil Defense. The need for such an emblem is great in that the Red Cross can only be used to protect medical personnel attached to the armed forces. There is a distinct need for an emblem of protection for those who will care for the civilian casualties in either international or civil war.

The emblem is a red sinuous line, representing a serpent, entwined on a vertical staff, displayed on a white field. (See illustration 2.) In order to be effective, this emblem must become as well known as the Red Cross. Therefore, it must be approved by medical associations and by the governments of the world. At this writing, 25 national medical associations have approved the emblem, including the American Medical Association. Only two governments have approved it, manifesting the fact that this will require an international convention similar to the Geneva Conventions of the Red Cross.

A final accomplishment of this Association is in observation and reporting of the activities of other international organizations, for example the Red Cross and the World Health Organization (WHO). The World Medical Association (WMA) makes a point of distinguishing itself from the World Health Organization (WHO), which is strictly an intergovernmental health agency formed by the United Nations and supported by the United Nations. WMA is completely non-governmental and operates on a budget 1% that of WHO. (WHO has a budget of $18,000,000 and the World Medical Association a budget of $217,000.) The backbone of support for the World Medical Association comes from voluntary activity of men like yourselves and from dues ($10 annually per person in the United States). Therefore, the United States Committee is made up of men who realize that there is just as much need to support WMA as there is to support county, state and national medical society activities.

MEMBER BENEFITS

Each year, WMA holds an essential and significant meeting, the General Assembly. At this meeting, it reviews its aims and accomplishments for its members, and strives to improve its philosophy and action as it seems indicated in light of contemporary medical thought. Steadily and surely, it is growing to encompass the medical ideals of all nations while maintaining the atmosphere of friendship and good will which led to its formation. The General Assembly has met 15 times since 1947 and in as many countries. Four times it has met in the Western Hemisphere, with the remaining assemblies in Europe or Asia. In 1961, Rio de Janeiro, Brazil was the site of the Assembly. In 1962 the meeting was held in New Delhi, India. In 1963, the WMA General Assembly will be in Mexico City. The 1962 meeting in India planned to have at New Delhi the leading practitioners of the globe discussing "Rural Medicine and Health." Inasmuch as this topic has been exhaustively studied in national medical meetings, this Assembly will concern itself more with the impact of industrialization and population changes. Besides being a meeting to discuss policy, programs and codes, the Assembly has arranged hospital visits, clinical research demonstrations, and historical and cultural features.

Introduction to professional leaders of the world is a second benefit of membership. One cannot attend a meeting without being personally introduced to many famous and enjoyable persons. The impressive thing about these introductions is that they are spontaneous — an organized introduction being unnecessary because of the spirit of good will which this body engenders. Even though these meetings are of men from all areas of the world, you would be pleased to see how they work together as if they were all members of the same clinic group or office. It is not at all unusual for a member from South Dakota to enter into conversation with Dr. Gunnar Gunderson and Dr. Gerald Dorman about pheasant hunting, as recently occurred at the WMA meeting held in Chicago in conjunction with the Annual A.M.A. meeting. You would have the impression that these men are interested in YOU and discussing with you your mutual interests. It is refreshing.

Thirdly, WMA sends out, on request, information on world medical meetings and arranges appointments to visit medical institutions abroad. One of the finest services given its members is a Travel Department which will arrange for you to visit any country you wish, in the free world, as an official observer for the United States Committee. They will arrange letters of introduction to men in your particular field of

interest, buy your ticket at the most economical rate you choose, and even arrange your travel in the United States. This service is also free to its members.

The WMA JOURNAL is a fourth benefit of membership. With a circulation of 15,000, it is well-written, comes as a benefit of membership, and is a perfect way for those of you who study a foreign language to brush up on French or Spanish, with the help of a built-in "pony" in the English section!

Each year a certificate is sent to all members of the United States Committee, and you would be surprised at the comments you receive from patients who notice this certificate hanging on your wall, and who had no idea that your fame has spead so far!

Probably the most important benefit of membership in WMA is the satisfaction you will have in supporting it. Here is a way in which you can work all over the world in protecting the freedoms essential to good medical care. Here is a way to prevent further invasion of socialization. Here is a way of promoting national and international good will, and this organization can allow you to give your enthusiastic support in almost any field you wish.

THE U. S. COMMITTEE

The United States Committee is the supporting arm of the World Medical Association in this country. Its officers are:

Dr. Austin Smith, President and Chairman of the Board
Dr. Harry J. Loynd, Vice-President
Dr. Gerald Dorman, Secretary-Treasurer
Dr. Gunnar Gunderson, Chairman, Council of WMA

These men are the task-force of the U. S. Committee and are doing an admirable job. Under their leadership, several new programs have emerged, among them the Medical Diplomats, and the Doctor-to-Doctor program.

The members like to think of themselves as Medical Diplomats, the origin of the term





MEDICAL CIVIL DEFENSE EMBLEM

EMBLEMA MEDICO DE DEFENSA CIVIL

EMBLEME PROTECTEUR
POUR
UNITES MEDICALES CIVILES

MEDICAL CIVIL DEFENSE EMBLEM

This emblem has been agreed upon by a committee composed of representatives of The World Medical Association, the International Committee of the Red Cross, and the International Committee of Military Medicine and Pharmacy and ratified by The World Medical Association as the one to be adopted nationally and internationally to protect doctors, ancillary medical personnel, medical units and equipment engaged in civil defense just as the Red Cross protects such personnel and units in the armed forces.

EMBLEMA MEDICO DE DEFENSA CIVIL

Este emblema ha sido acordado por un comité compuesto de representantes de La Asociación Médica Mundial, el Comité Internacional de la Cruz Roja y el Comité Internacional de Medicina y Farmacia Militar, y ratificado por La Asociación Médica Mundial, como el que debe ser adoptado nacional e internacionalmente para proteger a los médicos, el personal médico auxiliar, las unidades médicas y el equipo dedicado a defensa civil, así como la Cruz Roja protege a tal personal y unidades en las fuerzas armadas.

EMBLEME PROTECTEUR POUR UNITES MEDICALES CIVILES

Cet emblème a été approuvé par un Comité composé de représentants de l'Association Médicale Mondiale, du Comité International de la Croix Rouge et du Comité International de Médecine et de Pharmacie Militaires et ratifié par l'Association Médicale Mondiale comme l'emblème devant être adopté sur le plan national et sur le plan international pour protéger les médecins, le personnel médical auxiliaire, les unités médicales et leur équipement engagés dans la défense civile, tout comme la Croix Rouge protège ce personnel et ces unités dans les forces armées.

(Illustration 2)

coming from an interesting play on words by Dr. Gunnar Gunderson, Chairman of the WMA Council; past-President of the American Medical Association, and a director of WMA's United States Committee. He explains it this way: "We can add new meaning to the M.D. degree — Medical Diplomacy. World Peace cannot be obtained until we build peace into the hearts and minds of men. Since physicians are the most intimately acquainted with the physical and mental needs of their patients, they are the most logical engineers for this great moral reconstruction project. If we more than half million physicians assume this task on an individual, personal basis, we may yet succeed where soldiers, statesmen and politicians have previously failed." These are well chosen words from the heart of a great man. Study them. They were meant for you.

The program which is receiving great support now is the Doctor-to-Doctor program, by means of which physicians in distant lands are receiving periodicals and textbooks from members of the U. S. Committee. In turn, the physician in the foreign country sends one of his periodicals to the U. S. member. It is, in a sense, a matching program and has been well received in all lands. More than 700 members of the U. S. Committee are sending periodicals to foreign physicians, at their own expense. There are actually thousands of requests yet to be filled, as new donor-volunteers are found. The needs are apparent. From South Korea alone, there are now 2500 requests unfilled. Everyday new donors are found, and you will find it enjoyable to be a member of the U. S. Committee if only to be involved in this program!

Another new program of the U. S. Committee is the dissemination of used medical equipment to foreign countries. It has been pointed out that many physicians would experience the same pride in receiving and using your discarded equipment that you felt when the newer model replaced the old. The main benefit of contributing to such a program is the pleasure of making a friend of a physician halfway around the globe.

Those of you who are interested in this group can signify your willingness to help in this program of world-wide scope by writing:

Miss Margaret Natwick
Executive Assistant
U. S. Committee
World Medical Association
10 Columbus Circle
New York 19, New York

Every vital organization has a person because of whom it and the world are better off. Miss Natwick is this person for the U. S. Committee. Write her and you will be her friend, I warn you!

The House of Delegates of the American Medical Association by resolution has urged every physician to become a member of the U. S. Committee. How about you?

SUMMARY

The aims, accomplishments and benefits of the World Medical Association and its U. S. Committee have been presented, with the suggestion that the physicians of South Dakota support this organization. It is a good time to recall the words of Edmund Burke, who said: "All that is necessary for the triumph of evil is that good men do nothing."

WHAT WOULD HAPPEN TO YOUR PRACTICE . . . IF NO PATIENT EVER CAME TO SEE YOU AGAIN?

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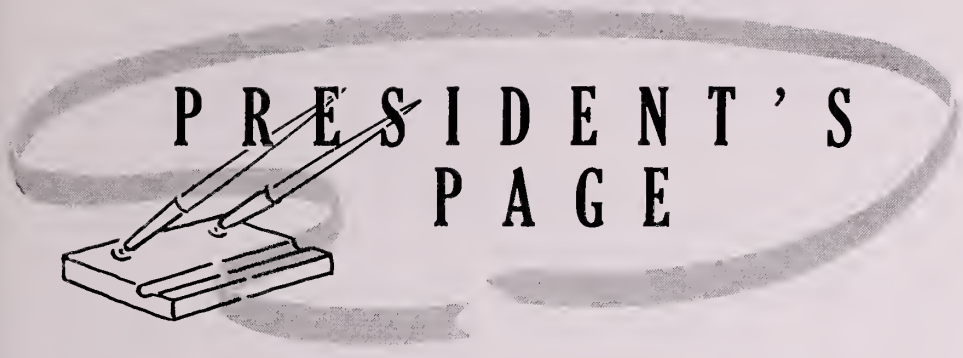
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Dear Fellow Members of the South Dakota State Medical Association:

One of the most important projects that we, as doctors, can support is the South Dakota Medical School Endowment Fund.

This fund is used to provide loans to students enrolled in the School of Medicine at the University of South Dakota. Every dollar that you contribute is used for loans, and none of the money is used for administration. The Medical Association administers the fund within the confines of the yearly budget.

In the past few years, it has become apparent that many physicians have forgotten the Endowment Fund. Last year only 62 contributed to this worthy cause.

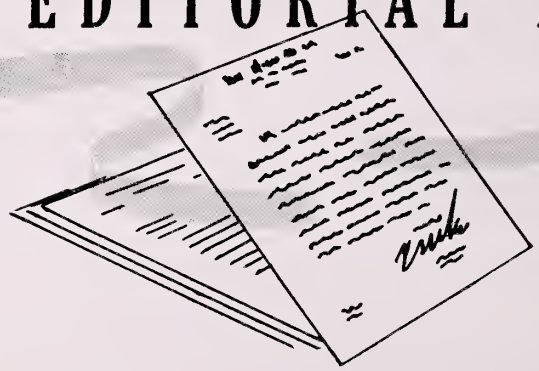
At this time, I am making a plea to each physician to contribute one dollar ($1.00) for each year of practice, or if possible, a larger amount. If each one would contribute a minimum of $25.00, we would have about $10,000.00 per year for new loans to students.

Make your check out to "Medical School Endowment Fund" and forward it to the executive office in Sioux Falls.

Magni Davidson, M.D.

President

EDITORIAL PAGE



NEW DISABILITY PLAN

On January 13th, your Council voted to officially approve the first true group income protection program ever written for the South Dakota State Medical Association. After ten months of careful study, plus a comprehensive survey of the membership at large, the Combined Insurance Company of America was awarded the contract to duplicate the coverage of the present plan on the new true group basis.

The true group approach gives us a more cohesive insurance unit and maximizes our group purchasing powers. Thus, the first effect is a substantial savings of premium dollars for our members. Next, because the program will be administered by a native South Dakota Agent, J. D. McGreevy, we are assured of constant care and attention. In addition, each and every year the Combined Insurance Company of America will give to the Council a status report showing a full and complete disclosure of how the premium dollars collected from our members were distributed. With this report, and acting as a large united group, your Association will always be in a position to render intelligent assistance and control.

Also, your master policy will have an arbitration clause for the disposition of any disputed claims. This clause is binding on the insurance company, but in no way does it restrict the rights of our members. We are one of the rare associations who actually have this provision incorporated in the policy.

Regardless of physical condition, the Combined Insurance Company has agreed to issue a policy for identical coverage and limits, to every member who desires to transfer from the presently sponsored income plan to our new true group program.

Within the next few weeks, brochures will be mailed to each member of the Association; they give simple instructions for joining our true group plan. Naturally, there is no compulsion to transfer or to even apply for the new program. However, past experience and present observation certainly prove the stability, quality and value of this contract.

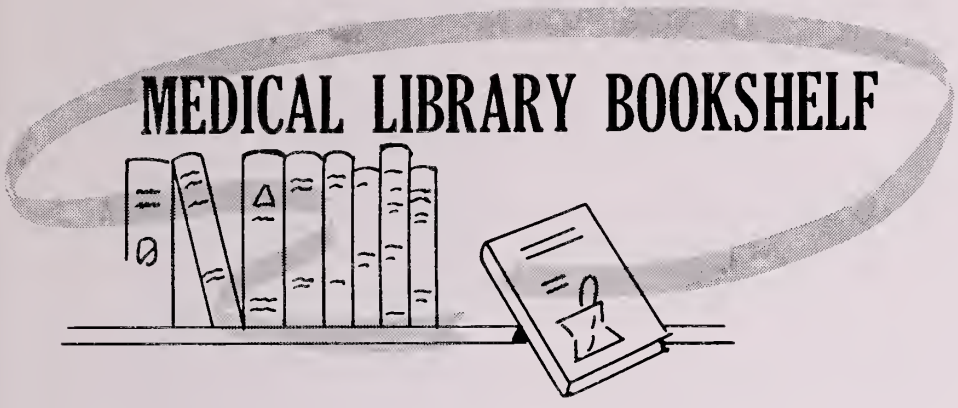
JCF

E. E. GAGE, M.D.
1874-1963

Dr. E. E. Gage, Sioux Falls, passed away on January 25th, after a lingering illness.

Born July 28, 1874, in Grundy County, Iowa, he moved to Hartford with his parents when he was six years old. He graduated from Sioux Falls College in 1897 and then taught in a rural school. He attended the University of Nebraska Medical School, graduating in 1903. His first practice was in Montrose.

In 1918, he located in Sioux Falls, where he became one of the founders of the Sioux Falls Clinic. He was married in 1897 to Minnie Butler who survives him. Dr. Gage was active in the local medical society, the First Baptist Church and the Masonic Lodge.



BOOK REVIEWS

The Deafness Research Foundation was organized in 1958 as the only national voluntary laymen's organization devoted to the support of investigation into the causes, prevention and cure of impaired hearing. In spite of the fact that 17,000,000 Americans, including 3,000,000 children suffer from impaired hearing, less medical research has been done in this field than in that of any other chronic disease.

Temporal Bone Banks

In order to promote research on the auditory and vestibular systems, which has been handicapped by a lack of human structures, the Deafness Research Foundation, in cooperation with the American Academy of Ophthalmology and Laryngology has launched a nationwide program to establish temporal bone banks. To date a network of 22 of these laboratories or "ear banks" has been set up in universities and hospitals throughout the country to investigate temporal bones of persons whose deafness was medically documented during life.

To be of value in research the bones must be removed immediately after death, and the pledgee carries a card requesting that this be done. The techniques for acquiring and preparing these bones are described in an article entitled "The techniques for acquiring and preparing the human temporal bones for the study of middle and inner ear pathology" found in the **Transactions of the American Academy of Ophthalmology and Otolaryngology,** September - October 1961, p. 784-788.

The physician is urged to inform patients with auditory and vestibular problems of this Temporal Bone Bank and explain how they can "pledge their ears for research." Instructions and pledge forms for this may be obtained from the Deafness Research Foundation, 310 Lexington Ave., New York 16, N. Y. or Temporal Bone Bank Center, P. O. box 146, Faculty Exchange, University of Chicago, Chicago 37, Illinois.

To date this program has helped laboratories pursue investigations of pathologic conditions that accompany such forms of deafness as Meniere's disease, otosclerosis, labyrinthitis, congenital deafness, deafness following various childhood diseases and many of the obscure types of vertigo.

Dr. George T. Nager, assistant professor of Otology and Laryngology at Johns Hopkins University developed a new operative technique for treatment of congenital aural atresia as a result of this program. In an article in **Postgraduate Medicine,** v. 29, 1961, p. 529-541, Dr. Nager describes "Aural Atresia: Anatomy and Surgery." This is summarized by Dr. Nager as follows: "A new operative technique for the treatment of aural atresia is described which has been used in the last five patients with this anomaly treated surgically at the Johns Hopkins Hospital. All five patients attained serviceable hearing and in two the hearing level is better than 20 db for the speech frequency range. The operation consists of creation of a tympanic membrane and construction of a func-

tional sound-conducting system, with maintenance of the ossicular chain, even though deformed. The great majority of cases of aural atresia are suitable for surgical treatment. Aural embryology, pathology and pathophysiology are reviewed."

The technique for this operation is given in some detail with illustrations. The underlying principle of operative treatment is reconstruction of a sound conducting system with an effective impedance-matching mechanism. Such a system includes an air-containing middle ear cavity closed by a movable membrane in contact with a freely movable ossicular chain or stapes. This tympanic cavity must have connection with the nasopharynx by a functioning eustachian tube. The cochlear fenestra also must be intact.

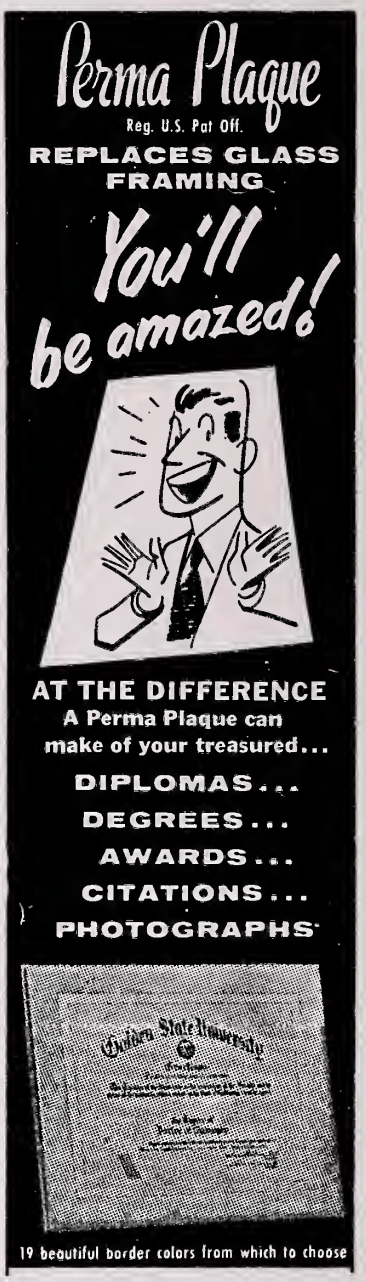
This article is valuable also for the description of the embryology of the ear with causes of malformations and developmental anomalies.

The April-May-June, 1962, v. 14 issue of **Clinical Symposia** is on Otologic Diagnosis and the Treatment of Deafness. This is superbly illustrated by Frank Netter and includes brief descriptions of the physiology of hearing; hearing tests; hearing aids and rehabilitation; the deaf infant; deafness in older children and adults; serious and chronic otitis media; Meniere's disease; acoustic accidents and otosclerosis.

Esther Howard
Medical Librarian

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"Fourteen man Iowa group has opening for Board qualified Internist. City of 30,000, new Clinic Building, complete laboratory and X-ray. Partnership in two years—salary open. Write Box A-1, Journal of South Dakota State Medical Association."



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MEDICAL ASSOCIATION

NEWS • NOTES • • • BIRTHS • • • CHANGES • NEWS

Pop's Proverbs

A deaf person is lucky not to **hear** unkind remarks.

NEWS NOTES

Dr. John B. Gregg, Sioux Falls, was recently named an honorary member of Sigma Alpha Eta, national speech correction society at the University of South Dakota. He has also been appointed Chairman for North and South Dakota by THE DEAFNESS RESEARCH FOUNDATION which is sponsoring the Temporal Bone Banks program, similar in principle to the Cornea Banks. It is the purpose of this program to obtain bequests of temporal bones for research in hearing problems and for instruction purposes. Physicians knowing of individuals who desire to donate temporal bones to the program or who desire information relating to this matter should contact Doctor Gregg.

Named to honorary life membership in the South Dakota State Medical Association in January was **Dr. L. L. Parke** of Canton.

* * *

The Britton Clinic moved into a new building in January.

* * *

Drs. Kemper and **de Almeida** moved into their new clinic building in Viborg in January, holding an open house on the 13th.

* * *

Dr. Marion Cosand, formerly at Fremont, Nebraska, has moved to Winner where he will specialize in surgery.

* * *

Dr. L. B. Vaughn, who practiced in Hurley until 1931, passed away in Long Beach, California on January 6th.

* * *

Dr. V. C. Marr of Estelline Clinic attended Continuation course in Cardiovascular Diseases at the University of Minnesota Center for Continuation Study of the General Extension Division.

POLIO VACCINE REPORTS MADE

Total cases of polio have decreased so tremendously since the two polio vaccines were put on the market that a recent report sums up the remarkable decrease in the disease by saying that the disease is obviously headed for oblivion. The average number of cases in the United States between the years 1951-54 was 40,000. In 1961, this dropped to 1,312; and in 1962 dropped to 88.6%, a decrease from the average of 97.8%.

In South Dakota, the average cases per annum in the 51-54 period totalled 371, with 27 of these being paralytic. In 1961, there were 4 cases reported, with 2 being paralytic; and in 1962, only 2 cases were reported, with both of them being paralytic.

The only area to reverse this trend, nationally, was the State of Texas where they had an increase between 1961 and 1962, yet were down 90% from the average of 1951-54.

MEDICAL RESEARCH THREATENED

Antivivisectionists, parading as "humane societies," are again threatening the future of medical research as they ready legislation to present to the new session of congress.

They are better organized, more sophisticated in approach, and more dangerous in the threat they pose than ever before. They are now preparing grossly restrictive legislation following their sympathetic treatment when testifying on the Moulder and Griffiths Bills. We propose to counter them with meaningful, progressive bills of our own. When the proposals of both sides are known, you will be alerted since all possible help is needed to secure the future of sound, productive medical research.

National Society for Medical Research
Lewis T. Bullock, M.D.
Chairman, Committee For Constructive Federal Policy on Laboratory Animal Care.

America's protection against smallpox has reached a "dangerous low," the American Medical Association warned.

In a statement adopted by the House of Delegates at the association's clinical meeting in Los Angeles Nov. 28, physicians and the public were urged to reverse "the declining immunization level against smallpox."

The statement said:

"Maintenance of protection against this serious epidemic disease requires revaccination at five-year intervals.

"A growing amount of international travel, at increasing speeds, to and from areas of the world in which smallpox is prevalent, persistently threatens to introduce the disease into the United States. Recent outbreaks in other Western nations emphasize the need for attention to this problem.

"The American Medical Association, in the interests of national safety, urges physicians and their patients, particularly those who may be in contact with possible carriers, to maintain the needed protection against smallpox.

"In implementing this proven phase of preventive medicine, the American Medical Association solicits the cooperation of other health organizations and agencies."

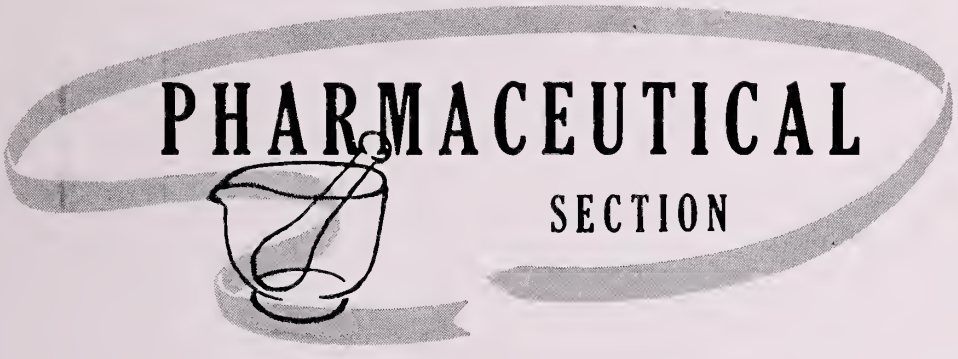
COMING MEETINGS

1963 Scientific Session
A Conference on **Unusual Forms and Aspects of Cancer in Man**
American Cancer Society
Biltmore Hotel
New York City, New York
October 21-22, 1963

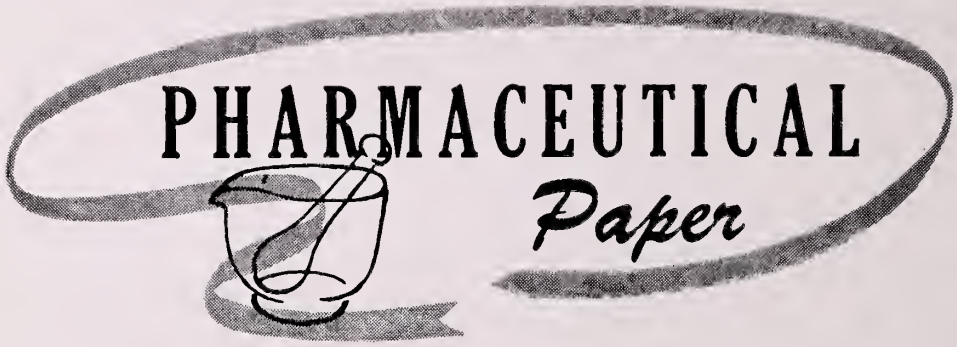
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The Hahnemann Medical College and Hospital is sponsoring a postgraduate symposium on the subject "The Theory and Practice of Auscultation" on April 15-17, 1963. The meeting will be held at the Sheraton Hotel in Philadelphia, Pa. For further information contact Bernard L. Segal, M.D., Symposium Director, Hahnemann Medical College and Hospital, 230 North Broad Street, Philadelphia 2, Pa.

FOR SALE: G. E. Model R-39 x-ray machine with accessories. Dr. G. L. Barnett, 1320 S. 8th Ave., Sioux Falls, South Dakota.



GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota



MODERN DERMATOLOGICAL VEHICLES THEIR NEED AND USAGE BY THE CLINICIAN*

Ralph Behling, M.D.
San Mateo, California

What Is The Skin?

Amphoteric protein gel of varying degrees of hydration. Least hydrated at surface (10-25%) with pH 4.2.-5.6. Water content increases in lower levels.

Functions Of The Skin

Functions of the skin include control of body temperature; the excretion of water and oil; the control of water loss; the protection of the body from mechanical, chemical and actinic injuries; the storage of chemicals; the initiation of most of the allergic responses of the body; and the reception of sensory stimuli. These functions are interrelated, difficult to study, and thus far have not lent themselves to scientific measurement.

Response To Injury

Skin which is subjected to noxious stimuli of any sort can respond in a limited number of ways. For example, an injured skin may urticate, or become necrotic and ulcerate, or vesiculate and ooze, or thicken and lichenify, or scale, and so on. A small area or the entire skin may react and the response may involve the entire thickness of the skin, or, for example, only the follicles, or only the stratum corneum. The type of response to injury will vary with the kind of injury, with the severity and duration of the injury, with the area injured, with the individual skin and with the individual owner of that skin to name a few variables. With some types of injury the response may be characteristic and reproducible while in other instances there may be marked differences in the response to the same stimulus, both between individuals and even at different times in the same individual.

The vehicle is of prime importance in the prescription of skin diseases. In all other fields of medicine the vehicle is of little importance as long as it is non-toxic, palatable and compatible. On occasion the vehicle assumes importance when one of these characteristics is lacking as in the case of toxic sulfonamide elixir which caused many fatalities a few years ago. And in the case of Hadacol the vehicle seems to have been of prime importance. This is one of the very few exceptions when the efficacy of an internal drug depends upon the proper choice of the vehicle.

In spite of the old saw — the vast majority of skin patients do get well and usually fairly rapidly. Even such bugaboos as psoriasis respond as well or better than peptic ulcers or

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* Presented at the 20th Annual Convention of the American College of Apothecaries, San Francisco, California, September 29-October 2, 1961.

rheumatoid arthritis. And most of the beneficial effect of treatment stems from the effect of the proper vehicle plus dermatological know-how, rather than some magic ingredient.

Aims Of Topical Therapy

Then I think we can make a basic statement in regard to topical medication: to be of therapeutic value a medication must (1) prevent or correct the effects of noxious stimuli producing or contributing to the disease, or (2) correct or aid the skin in performing its functions. A third, giving comfort to the patient, may involve both of these therapeutic lines of attack. I have purposely ignored what might be called a "stimulus to healing." The existence of such a drug is highly questionable at present. Two or three times in every decade a new treatment for the healing of leg ulcers is proposed. One was cysteine hydrochloride, this amino acid was sold with an advertising blurb which warned the physician to apply it with care since it was so stimulating to epithelial growth that it might be carcinogenic! Actually it was about as effective as normal saline, though several hundred times more expensive. Since then we have had cod-liver oil, split leaf of Aloe vera, chlorophyl, red blood cells and so on. The best of these do no harm; some of them act as a foreign substance and delay healing. So far no treatment better than wet dressings of boric acid or saline, along with bedrest, has been devised. I feel sure that someday we shall have drugs which actually stimulate epithelial healing, speeding cell division and growth through hormonal, catalytic or enzymatic action.

If, up to this point then, I have sounded suspiciously like a therapeutic nihilist, let me hasten to assure you that I am not. At least not by my definition. I am not credulous and have enough show me to have come from Missouri. But I will buy any treatment which I can demonstrate myself to be effective and valuable.

Pharmacology Of Dermatologic Vehicles

Let us proceed now to the heart of the problem, the pharmacology of topical cutaneous medication. There are several different types of vehicles and many minor variations. In choosing the proper vehicle one must take into account three basic factors: (1) the characteristics of the skin to be treated, (2) the characteristics of the vehicle, and (3) the desired action or effect on the skin.

(1) The characteristics of the skin to be treated include not only the type of dermatitis to be treated, whether it be edematous and oozing, or dry and scaly, but also the oiliness, dryness, sweatiness or intertriginous position, hairiness, covering of clothing, exposure to light and the like.

(2) The characteristics of the vehicle can best be shown by a simple classification of vehicles which one may set up as follows:

1. Aqueous Mixtures, including baths, packs, lotions and gels of hydrophilic colloids.
2. Liniments, in essence oily lotions.
3. Ointments, subclassified as follows:
   - A. Oleaginous Bases—water immiscible and insoluble
   - B. Absorbent Bases—water miscible but insoluble and anhydrous
   - C. Emulsion Bases
     1. W/O—water miscible and hydrous but insoluble and non-washable
     2. O/W—water miscible, hydrous and insoluble but washable
   - D. Water Soluble Bases — anhydrous, greaseless and completely washable
   - E. Pastes and collodions as special items
4. Powders, which may be hydrophobic or hydrophilic.
5. Organic solvents.

The desired effect of the vehicle is the third basic factor. Theoretically a topical medication can act in one of four ways: (1) by direct chemical action on the skin or on the causative agent, (2) by altering the physiology of the skin, (alcohol removes sebum) (3) by inducing an immune reaction in the skin (smallpox vaccine), and (4) by its physical or physico-chemical action on the skin.

In dealing with vehicles the first two are unimportant and the third is practically always an unwanted complication of treatment. Thus the physical and physico-chemical effect is the only one of major import.

These physical effects may be listed as follows:

1. drying effect
2. emollient effect, increasing softness and suppleness
3. warming effect
4. cooling effect

5. protection from chemical and physical trauma
6. transportation of medication to the skin surface, and effect on the penetration and absorption of the medicament
7. removal of secretions and debris

Five other factors related to the foregoing must also be considered: (1) the compatibility of the vehicle for the skin area involved, (2) the compatibility of the vehicle with the type of dermatitis, (3) the compatibility of the vehicle with the drugs to be incorporated in it, if any, (4) the need, if any, for water-washability for ease of removal, and (5) the acceptability of the vehicle to the patient.

Let us take up these twelve items briefly but specifically. Vehicles used for their drying effect include water as packs and baths, lotions, gels, organic solvents, and powders. The drying effect, as the term is used, applies to the use of packs on oozing dermatitis, the use of powders on intertriginous areas, and also the use of alcoholic vehicles on excessively oily skins (example—acne). Emollient effect is obtained by the use of various preparations; namely, the Liniments, such as Calamine Liniment N.F., Water Immiscible Oils such as cottonseed oil and petrolatum, Water Miscible Oils such as anhydrous wool fat and Polysorb, Water-In-Oil-Emulsions such as hydrous wool fat and coldcream, Oil-In-Water Emulsions such as Hydrophilic Ointment USP, Pastes such as zinc oxide paste and Water-Soluble Ointments of which there is but one at present, the USP Polyethylene Glycol Ointment. The Hydrophobic Powders and Gels have some emollient effect.

Generally speaking the water-immiscible oils exert the strongest warming effect upon the skin by interfering with perspiration and evaporation. The organic solvents, most notably ether, exert the strongest cooling effect, followed by non-occlusive wet packs, lotions, hydrophilic powders and gels. The emulsions and water-miscible oils, by interfering less with water loss from the skin, have less of a heating effect than the water-immiscible oils.

Protection of the skin from chemical and physical trauma can be given a narrow or a broad concept. The oils, pastes and collodions give the best protection against chemical irritants commonly contacted and also against mechanical injury from rubbing and scratching. The addition of powders such as zinc oxide and starch to give body to the oils increases their protective power, and the silicones promise even better protection against chemical irritants. Other physical trauma such as drying and cooling have already been discussed. Protection from actinic energy in some wave lengths can be accomplished by greases and other vehicles by the addition of specific chemicals.

The relationship of the vehicle to the drug as a carrier and the promotion of penetration and absorption, are complex subjects, depending upon the solubility of the drug in the vehicle, the volatility of the vehicle, and the ability of the vehicle to permit transfer of the drug to the skin. In true solutions the particle size is molecular or smaller and in colloidal solutions the size is somewhat larger; in either case the particles move about freely and theoretically all of the drug, not just that at the interface is available to the skin. In suspensions this motion does not occur and the availability of the drug to the skin is much decreased. And increasing the concentration of the soluble drug in the vehicle results in a proportionate increase in the effect, at least theoretically, whereas increased concentrations of drugs in suspensions does not result in any such increase in effect.

Evaporation of the vehicle, or of part of the vehicle, will materially change the concentration of the drug, the movement or availability of the drug particles, and the state of solution. Evaporation which leaves a concentrated residue of the drug on the skin may also leave it in a relatively unavailable form. The advantage of having a water-soluble drug in an oil-in-water emulsion disappears once the water has evaporated, leaving the water-soluble drug relatively unavailable in a greasy vehicle.

The transfer of the drug from vehicle to skin depends upon the relative solubility of the drug in the vehicle and in the oil or aqueous surface film on the skin and upon the miscibility of the vehicle and this surface film. In general we can say that oil-soluble drugs will be transferred most easily from an oily vehicle to an oily skin film, and a water-soluble drug best from an aqueous vehicle to an aqueous surface. The addition

of wetting agents will establish a better interface between the vehicle and the skin and provide better dispersion of insoluble drugs, thus aiding in the transfer of the drug to the skin. Penetration and absorption of drugs through the skin is still being investigated and our knowledge is far from complete. The problem concerns the mode of entry of the drug through the skin, the effect of solubility relationship, the possibility of absorption of the vehicle itself, and the varying characteristics of the skin itself.

It is possible to state that the intact and normal skin is a rather effective barrier to the absorption of drugs, although some drugs are so absorbed in considerable quantity. Inflamed or denuded skin absorbs drugs far more readily, particularly water-soluble drugs from aqueous vehicles. Heat and rubbing increase absorption and there are variations with age and the site involved. Work at Iowa and elsewhere is still in progress on this problem and our knowledge is incomplete. It is important to remember that percutaneous absorption does occur and that toxic amounts of certain drugs may be absorbed from topical applications.

The removal of cutaneous secretions and debris is usually accomplished with packs and baths of aqueous type, and less commonly with organic solvents and hydrophilic vehicles.

The compatibility of the vehicle for the skin area involved refers to the advantage of lotions, powders, gels, and perhaps water-soluble and water-miscible materials on sweaty, intertriginous areas, to avoidance of heavy ointments in hairy areas, and the like.

The compatibility of the vehicle for the type of dermatitis refers to the difficulty of application of oils and greases to oozing dermatitis and the general ineffectiveness or harmfulness of such treatment, as opposed to the use of aqueous vehicles on such skin. Heavy ointments are often preferable on chronic scaling dermatitis.

The requirement of compatibility of the vehicle and drug is, of course, of utmost importance. Certain drugs, particularly the combinations of salicylic and benzoic acids, have a marked tendency to break down many of the newer emulsion bases, for example, and in other cases insolubilities and chemical reactions may prevent certain combinations of drug and vehicle.

Water-washability may be desired where part of the therapy includes baths or packs which would be interfered with by greasy vehicles, and in the scalp where heavy greases are difficult to remove from long hair.

Finally the comfort and sensibilities of the patient cannot be ignored. Light oils may be better tolerated than greases in exfoliative dermatitis. Greasiness is distressing to some and wetness to others. The likes and dislikes of the patient must be secondary to the rest of the therapeutic criteria, but must be considered, particularly where there may be little real difference in efficacy between two vehicles, one pleasant and the other not.

As you can see from the foregoing, the dermatologic vehicle must be considered in a wholly different light from such internal vehicles as syrups and wines. Each vehicle has certain very definite effects upon the skin, largely physical in nature, and these effects on a given skin lesion should govern the choice of the vehicle. And much of the therapeutic effect in dermatologic treatment depends upon these physical effects.

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339-3670



FACTS ON THE USE OF PESTICIDES*

In the more than 75 years that man has employed chemicals to control insects, fungi, rodents, weeds and other pests, he has become increasingly dependent on them. This trend has been especially evident since World War II. In general, chemical pesticides have proved highly effective in attaining desired goals, although they have certain objectionable aspects. One of these is their actual or possible hazards to man and other forms of life. Individuals, of varying degrees of competence to make critical judgments in this field, have urged a drastic curtailment in pesticide use, and even a discontinuance of most of the synthetic compounds introduced in the past 20 years.

Since our economy, health, and recreational activities depend in large measure on the use of chemical pesticides, it seems timely and in the public interest to make an objective assessment of all aspects of this important subject.

Do We Really Need Pesticides?

This is hardly a debatable question. We not only need them, we are highly dependent on them, especially in the production of food and fiber crops. Without pesticides we would eat very poorly indeed in terms of both quality and quantity. Millions of people are alive today because of the use of DDT and other modern pesticides in suppressing insect-transmitted diseases of man such as malaria, yellow fever, and typhus. Witness, too, how we are relying on pesticides to stamp out the current outbreak of encephalitis in Florida. But if we use these materials, we cannot hope to be free from all possible objectionable consequences of their use. One such problem, for example, is the traces of pesticides that unavoidably may persist in or on some of our food crops beyond harvest.

Do These Traces of Pesticides Constitute a Health Hazard to Consumers?

According to the best scientific evidence available, the traces that are allowed — and these are fixed by the Food and Drug Administration — constitute no known hazard. This question of allowable levels involves the "tolerance" concept. Its principle can be illustrated with table salt. As used in our foods, salt is employed at a safe or tolerable amount — for most individuals. At higher levels, however, it becomes a "poison." This was tragically illustrated in a Binghamton, N. Y., hospital recently when salt was accidentally substituted for sugar in the formula fed to new-born babies. All chemicals have their safe and toxic levels. For "toxic" materials such as certain pesticides these levels are simply lower than for table salt.

Before any pesticide can be sold it must undergo extensive feeding tests on laboratory animals. These tests may be continued for two years or longer, and involve several generations and thousands of laboratory animals.

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* Prepared by the New York State College of Agriculture, Ithaca, and the New York State Agricultural Experiment Station, Geneva, units of the State University, at Cornell University; October, 1962.

The FDA sets a tolerance — zero or otherwise — on the basis of this information. This level always represents an amount far below any that may have shown the beginnings of trouble in test animals. It often reflects a hundredfold safety factor. Most laymen will still ask why we allow even these traces. Fortunately, much of our food is free from them. But what is the meaning of "free" when we now have instruments capable of detecting up to one part of pesticide in one billion parts of product? Short of not using the material at all, common sense calls for setting the allowable level low enough to meet all safety requirements yet not so low as to prevent the use of a needed product. This is exactly what the FDA attempts to do.

Do Pesticides Pose a Serious Threat to Wildlife?

As a preface to this section two facts should be appreciated: (1) The harm man has done to wildlife in felling forests, tilling fields, draining wet places, polluting waters, and through urbanization, is of much greater consequence collectively, than are the relatively small and temporary losses that have occurred from pesticide use. (2) Of the total land (and water) area of the U.S.A., more than 95 percent receives no pesticides in a typical year; in the wildlands (about 75 percent of the total area) the figure is 99 percent.

As currently used in routine operations to control mosquitoes and pests of our farms and forests, the hazards to wildlife are generally considered to be small. In the past, greatest losses have occurred in special eradication programs, especially where high dosages of pesticides were used more or less indiscriminately over large areas. In the light of present knowledge, some of these programs were unsoundly based. That professionals in this field have profited from past mistakes is evidenced by the highly successful eradication programs against the screwworm fly and the medfly that have been conducted recently in Florida. These were judged to have had little or no effect on wildlife. Wildlife protection is a common interest. Therefore, we can all subscribe wholeheartedly to a plea made by a committee established by the National Academy of Sciences — National Research Council to study pesticide-wildlife problems. It reported: "In order to hold wildlife losses to a minimum, scientists representing all of the disciplines involved should unite forces in an all out effort to identify and evaluate specific hazards and to develop corrective measures for objectionable practices."

Are Pesticides Upsetting the Balance of Nature?

This question implies that modern man is living under conditions of natural balance in relation to other forms of life. This is far from true regardless of where he lives, farms, or carries out his business enterprises. Man's progress, in fact, is largely measured by the degree to which he has been able to unbalance nature — to his advantage. It is often suggested that we use nature's tools to keep pests in check. Notice though, that there are no "pests" in nature. Pests are a concept of man. Species fluctuate periodically in numbers through competition with one another, but this is of no consequence under nature's grand design. Nature, we find, is usually much too slow and inefficient in control to meet man's standards. Anyone who has seen the eastern tent caterpillar totally defoliate wild cherry trees for two consecutive years before parasites, predators, and disease begin to get the upper hand will understand this. Scientists are exploring the possibilities of using biological methods in control. But experience to date shows that we cannot rely on them alone, particularly in intensive agricultural operations. To produce food at present high volume and quality we are dependent on chemical control measures primarily.

How much are pesticides misused? To some extent, of course. But such misuse is apparently no higher than occurs in any other similar human endeavor. A different logic seems to apply where misuse of pesticides is involved. This is the tendency to fix blame on the pesticide rather than on the person who misused it. When someone runs into a tree with an automobile, what or whom do we blame: automobiles in general, or the man who misused that particular one?

The number of farmers who willfully apply treatments nearer harvest than the law allows is quite small, for several reasons. Even if farmers were not law-abiding as a group — and they are — pesticides are expensive and farmers tend to use them only when needed. They know, too, that pest control treatments applied near harvest usually

are of little avail. Reference has already been made to the misuses that have occurred in relation to wildlife. We must also recognize that some pesticide misuses have led to serious illnesses and even deaths. Certain pesticides are toxic at low dosage levels, so in common with many other chemicals, fatalities can occur if they are accidentally swallowed, intentionally swallowed, or are handled with gross carelessness. There is no question that farmers, for their personal safety, should handle and use pesticides with respect. The pesticide safety record of the farm is remarkably high.

Should "Less Toxic" Pesticides Be Used?

No simple answer can be given to this question, as can be illustrated with two insecticides, parathion and rotenone. Parathion is considered, rightly, to be highly toxic to both insects and man; rotenone, on the other hand, is rated relatively "safe." The danger in parathion use is to the farmer who applies the material, not to the consumer who eats parathion-treated crops. This chemical disappears rapidly from spray deposits. It thus may be safer, from the standpoint of the consumer than some less toxic pesticide that lays down deposits highly resistant to weathering. Rotenone is relatively nontoxic to humans, but it is highly toxic to fish. In fact, it is commonly used to exterminate unwanted species of fish from certain ponds or streams before restocking with wanted species. It has been suggested in the interest of safety that plant-derived pesticides such as rotenone, pyrethrum, and ryania be used in place of DDT and the other synthetic organic pesticides. Although these well-known botanicals have found limited use over the years, experience has demonstrated that they are too inefficient generally to cope with the total pest problem. A primary goal of insect toxicologists is to find pesticides with maximum differential toxicity. These would be highly toxic to certain insect species but of low toxicity to man. Examples of such synthetic products are malathion and Sevin.

Are There Satisfactory Alternatives To Chemicals For Pest Control?

As of today, no. This is not intended to belittle nonchemical control principles. Some, such as the breeding of disease-resistant crop varieties, have proved to be highly successful solutions to certain problems. Even in such instances, however, chemical treatments may be needed to protect the crop from diseases and insects other than the one to which the plant is resistant. Other nonchemical principles being actively explored for practical application include: use of various microbial agents; use of insect and mite parasites and predators; manipulation of plant nutrition; and use of various agronomic principles, such as crop rotation and time of planting.

Another method that seems to have important possibilities is the genetic approach. A dramatic demonstration of its application is the eradication of the screwworm fly through mass releases of sterilized males. Sterilization can be effected by irradiation or more cheaply now, possibly, by use of certain chemicals (chemosterilants). The technique used to control the screwworm probably can be applied advantageously to other pests. But there are still other ways in which genetic principles can be manipulated to combat pests.

However, the final standard that all control measures must meet is: do they work? Thus for the foreseeable future we must continue to rely heavily on chemical methods to cope with critical pest problems. We will undoubtedly develop better pesticides — safer, more effective, and perhaps less subject to pest circumvention through the development of resistant strains.

Can Pesticides Induce Cancer or Cause Gene Mutations?

This is a consideration that flourishes better in the realm of speculation than in fact. Based on the same "evidence" in this area one can project a given assumption to mean almost everything, or, conversely, almost nothing. The list of substances that have been identified as carcinogens (cancer-producing) is very large. The number known to be mutagens (mutant-producing) is smaller but includes such well-known chemicals as caffeine and, possibly, table salt. The significance of such ratings of chemicals in terms of actual hazards to humans in normal exposure is a much debated subject among scientists.

None of the synthetic insecticides in use today is either carcinogenic or mutagenic. As a matter of fact, any that should be judged to be carcinogenic must, by present law, be given a zero tolerance. DDT has been

strongly suspected of being mutagenic by some persons. But in 1957 a well-known geneticist, Professor James F. Crow, reported: "This study shows that DDT as ordinarily used does not have a significant effect on mutation rate."

Conclusions

Both the chemical and nonchemical methods in use today to control pests are the result of research that has been done by thousands of scientists in state and federal agencies, in industry, in our universities, and in private institutes. These persons include entomologists, plant pathologists, chemists, horticulturists, agronomists, veterinarians, medical scientists, pharmacologists, wildlife specialists, and others. Collectively, they are aware of the areas of both strength and of weakness in all the methods in use. Where the limitations in a given method are serious, two courses of action are followed: one is to eliminate the objectionable feature if possible or to reduce its importance; the other is to find a new material or method that does not have the drawback.

The public can do two things to bring about a better program of pest control. One is to learn more about all aspects of this important subject. The other is to support research, especially on new approaches in which human health hazards are nonexistent or minimal, and to support programs that endeavor to establish the facts about health hazards, if any, in existing control methods.

"THE DRUG THAT WASN'T THERE"

Obviously we must make the investigation of new drugs as safe as possible. At the same time, we must not hamstring the medical research which alone can produce new curative agents for the future, and trials in humans are an essential part of the research process. It should be remembered that the "miracle drugs" produced by the pharmaceutical industry do, in fact, deserve this name and have played a major part toward increasing our life span by ten years in less than a generation. In the years to come "the drug that wasn't there" may bring greater tragedy than the drug which possesses unexpected toxicity. — Editorial in Cincinnati Journal of Medicine, November 1962.



PRESIDENT'S PAGE

Rx



February (I forgot, you'll be reading this in March), the month of famous birthdays: Washington, Lincoln and St. Valentine. Many other famous people born under the sign of Aquarius, the water bearer, include: Adlai Stevenson, Charles Darwin, Franklin D. Roosevelt, Margaret Truman, Jack Benny, and Tennessee Ernie Ford.

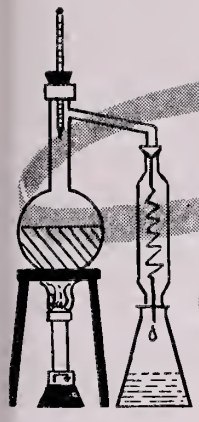
Regarding our fiasco with the State Legislature, I can only quote an old proverb: "Be sure the brain is engaged before putting the mouth in gear."

All this hurry, hurry to get to the moon can be explained by one of the following two reasons: (1) the New Frontier, looking for new sources of taxes, possibly would like to cut the moon in on the New Deal; (2) this rat race may exist because (as grandma told her grandchildren) the moon is really made of green cheese.

Sincerely,

L. B. Urton

President



Advances In Drug Research

CHEMIST PREDICTS GIANT MOLECULES TO OPEN NEW ERA IN MEDICAL RESEARCH

Entirely new types of drugs may soon be possible through new developments in polymer chemistry, techniques similar to those used by chemists to create plastics and certain other synthetic materials. As a result, we may be on the threshold of a new era in medical research, according to Dr. Herman Marks, Director of the Polymer Research Institute and Dean of Faculty at the Polytechnic Institute of Brooklyn.

Polymerization, the linking of molecules into a long chain to form a giant or "macromolecule," has a promising future in pharmacy, Dr. Marks said, although many problems must be answered before polymer chemistry can merge successfully with the biological sciences. However, a start has been made through recent advances in techniques and the availability of a variety of starting materials.

Speaking to the scientists of the Medical Research Laboratories of Chas. Pfizer & Co., Inc. at Groton, Conn., at one of their regular seminars, Dr. Marks said that some basic experimental studies to test the concept have already been made. From these tests, it appears that drugs designed so as to contain certain macromolecules would have several advantages over present ones. One of these is control over the speed and completion with which a drug is absorbed. Another is control of distribution in the body so that the physician can achieve the biological effect he wants only at the site he wants to treat. Reduced toxicity is another possibility and still another is increased selectivity.

As an example of this, Dr. Marks pointed out, a macromolecule might be designed to have a high affinity for cholesterol, the fatty deposit now blamed for clogging and narrowing the arteries in atherosclerosis. This could cause a reduction in blood cholesterol levels which might be significant in the treating of atherosclerosis.

Further advances in polymer chemistry, Dr. Marks pointed out, with increased knowledge in physical and biological chemistry could greatly help the cause of medical research.

WHAT IS DRUG SAFETY?

Safety is a relative thing; it can never be black or white. A drug which would be considered incredibly dangerous as a substitute for aspirin might well be useful in the treatment of a life-threatening disease. Furthermore, safety can only be judged in the light of current scientific information. As a consequence, a drug properly released as safe for use may later be made even safer by a technical advance. The World War II penicillin was made by production methods that today seem crude, but it saved countless lives. — John T. Connor, President, Merck & Co., to American Hospital Association, Sept. 18, 1962.



RECREATION, HEALTH DOLLARS ON PAR

The American public is spending virtually the same amount of money for recreation as it is for medical care, the Health Insurance Institute has reported.

Out of every dollar the public spends, 6.2 cents goes for medical care while 6.1 cents is spent on recreation, said the Institute in a report based on personal consumption expenditure figures compiled by the U. S. Department of Commerce.

These figures show that in 1961 Americans spent $338 billion on their personal needs. Of this total, $21.1 billion was spent on medical care.

Recreation expenditures amounted to $20.6 billion, said the Institute. In addition, $10.2 billion was spent on alcoholic beverages, tobacco products accounted for $7.6 billion, and personal business items which include bank service charges, legal service, investment counseling fees, and interest charged on personal debts, accounted for $21.6 billion. All four of these categories added up to $60 billion in public expenditures — or some 17.7 cents out of every dollar spent by the public — and nearly three times the expenditures for medical care.

Other personal expenditures in 1961 included $71 billion for food, $44 billion for housing, $40 billion for transportation, and $34.5 billion for clothing, accessories and jewelry, said the Institute.

Taken as a proportion of all personal spending, medical care expenditures have not increased sharply in the past 20 years, especially when the great progress made by medical science is taken into consideration, said the Institute.

Medical Care Dollar

In 1941, the public spent $81.9 billion for its personal needs, including $3.3 billion, or 4.0 per cent of the total, on medical care, compared to 1961's 6.2 per cent. However, there were marked changes over the same period in the distribution of each dollar spent for medical care.

From each dollar spent for medical care in 1941, physicians received 31 cents, 29 cents went for medicines and appliances, 21 cents went to hospitals, 14 cents to dentists, and five cents was spent on all other medical needs. In 1961, 29 cents went to physicians, 25 cents for medicines and appliances, 30 cents to hospitals, 10 cents to dentists, and six cents for other medical care. Expenses for health insurance were included in the distribution.

The $21.1 billion in medical expenditures in 1961 represents spending of both insured and non-insured persons. In addition to going for physicians, dentists, hospitals, and prescribed drugs, it helped pay for non-prescribed

drugs and medicines, eyeglasses, luxury hospital accommodations and many drug store purchases, including vitamins, sunglasses and cold remedies.

ROBERT L. SWAIN

Robert Lee Swain, president of the American Pharmaceutical Association in 1933-34, renowned pharmaceutical journalist, and a true "elder statesman" of pharmacy died February 4 at his home in Jackson Heights, New York. He was interred at Sykesville, Maryland.

Dr. Swain, who observed his 75th birthday last September, was born September 29, 1887 at Redden, Delaware.

He received the degree of Pharm. D. from the University of Maryland in 1909, and he practiced pharmacy in Sykesville, Maryland, from 1909 to 1928. He served as a member of the Maryland Board of Pharmacy from 1920 to 1940, and as secretary of the Board from 1925 to 1940. From 1922 to 1939 he was deputy food and drug commissioner of the Maryland Department of Health. His teaching activities included professor of pharmacy law at Temple University and as professorial lecturer on contemporary pharmacy at George Washington University.

In 1933, Dr. Swain became pharmacy editor of Drug Topics, and in 1939, he left Maryland to become vice president of Topics Publishing Co., and editor of their two publications. He served as editor-in-chief of Drug Topics and Drug Trade News until 1960, and his complete retirement was announced only last month.

He was named director of the National Association of Boards of Pharmacy Department of Education, and nine years later, he was elected President of NABP, and thereafter served for several terms as Treasurer of NABP. Dr. Swain also was named Chairman of the National Association of Retail Druggists Fair Trade Committee, and he was the author of the NARD "Fair Trade Manual."

He served for more than 25 years as a representative of the American Council on Pharmaceutical Education, and he was a director of the American Foundation for Pharmaceutical Education from 1940 to 1959, serving as President 1953-55. He served on the Board of Trustees of the USP from 1936 to 1960, and as chairman of the Board from 1945-60.

Dr. Swain was the Remington Medalist in 1939, and the recipient of many other honors in pharmacy. He held honorary degrees from Temple, U. Maryland, Philadelphia College of Pharmacy and Science, Ohio Northern, Washington College, Connecticut College of Pharmacy and the New England College of Pharmacy. Further tribute was paid to the "elder statesman" in May, 1960, with a testimonial dinner in New York City.

Dr. Swain is survived by his wife, Esther Beach Sprecher Swain, who resides at 34-22 81st Street, Jackson Heights 72, New York, and his son, Robert Swain, Jr., and two grandchildren.

ANNOUNCING THE DATES

of the

Ninth Congress of the Pan-Pacific Surgical Association:

November 5-13, 1963

in

Honolulu, Hawaii

and the

First Pan-Pacific Mobile Educational Lecture Seminar:

November 13-December 10, 1963

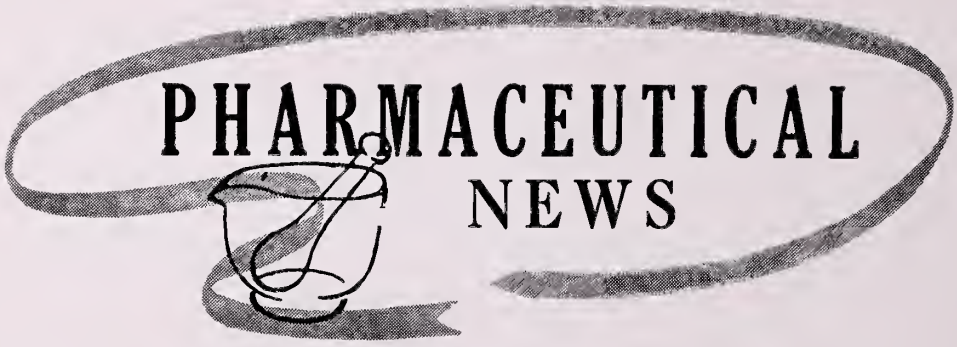
in

New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan

All physicians are cordially invited to attend both of these meetings. The Ninth Congress offers an extensive scientific program of 300 leading surgeons in nine surgical specialties.

The Seminar through the Pacific area offers, for the first time, scientific meetings in each country presenting medical material unique to the areas.

For further information, please write Dr. F. J. Pinkerton, Director General, Pan-Pacific Surgical Association, Suite 236, Alexander Young Building, Honolulu 13, Hawaii.



STATE COLLEGE STAFF MEMBER NAMED TO NATIONAL ASSOCIATION

Professor Clark T. Eidsmoe, Head, Department of Pharmacy, has been invited to become a member of the National Association on Standard Medical Vocabulary, as a consultant in pharmacy. The Association is a non-profit organization dedicated to the stabilization of the terminology of the medical and allied sciences. To be qualified for membership in the Association an individual must be on the faculty of a recognized school and have a rank not lower than assistant professor; and in addition, except in special cases, should have a doctorate, or its equivalent in one of the accepted arts or sciences.

1962 NEW PHARMACEUTICALS

Surpassing the 700 mark for the second time in history, the U. S. drug industry introduced 739 trade-named pharmaceuticals during 1962, according to pharmIndex pharmaceutical reference service.

The 739 new items issued by 256 manufacturers exceeds the previous record-high of 718 introductions from 232 firms in 1960, but probably does not truly represent record production, according to William C. Felter, pharmIndex publisher. Increased reporting efficiency probably more than compensates for the small 3 per cent increase over the two-year period, Felter believes.

Sixty-seven of the largest drug firms, those with full national distribution for their products, introduced 145 new items during 1962 for an average of 2.2 products, identical with the 1961 average when 139 new products were marketed. But in 1960 national firms introduced 210 products for a 3.4 average while 209 introductions created a 4.1 average in 1959. National manufacturers marketed 29 per cent and 27 per cent of the new products in 1960 and 1961 respectively but in 1962 they originated under 20 per cent of the new items.

Though 1962 may not be remembered for progress in pharmaceuticals, it will long be remembered for the changes which took place in the industry, particularly marketing. The year was filled with mergers, purchases and amalgamations which greatly added to the number of firms having full national distribution, even if the distribution was not to be used for new products immediately. From 68 national firms in 1959, the number rose to 74 in 1960, 83 in 1961 and jumped to 97 in 1962, although 30 of these were to introduce no new items in 1962.

Firms with less than full national distribution introduced new products at a higher rate than any time in the four-year history of the pharmIndex reports. One hundred eighty-nine regional firms marketed 594 new items for an average of 3.1

products each. These firms had averaged 2.3 introductions in 1959, which rose to 3.0 in 1960 and dropped to 2.5 in the problem year 1961. Regional manufacturers were able to introduce more items in 1962 than in the previous year in over two-thirds of the 22 pharmIndex product classifications while national manufacturers were able to increase introductions in only one-third of the classes.

In most years the national and regional firms market their highest percentages of new items in virtually the same classifications of products. Emphasizing the great difference in the 1962 marketings of the two types of firms is the fact they shared only one classification in products representing 10 per cent or more of the total introduced. Unable to market some of their new research developments, national manufacturers turned to careful examination of their total product lines introducing more standard types of products which they hoped would provide them with competitive advantages. Major classifications of introductions by national companies were: 1) Skin & dermatologic (14 per cent); 2) Respiratory & common cold (13 per cent); and 3) Cardiovascular (11 per cent). Regional firms showed the greatest activity in: 1) Respiratory & common cold (14 per cent); 2) Nutritional & vitamin (12 per cent); 3) Neurologic/psychosomatic (12 per cent); and 4) Gastrointestinal (11 per cent). Introductions by the regional manufacturers were so highly concentrated in these four classifications as to account for about half (49 per cent) of all their new products.

For the third consecutive year about one of every four new pharmaceuticals (22 per cent) contained a single major ingredient. An actual increase in the number of single ingredient products by regional manufacturers as well as the drop in new chemical entities marketed by national firms has created a marked shift in the source of single ingredient products. National companies introduced 45 per cent of these items in 1960, just 37 per cent in 1961 and only 21 per cent in 1962.

In addition to the 739 new products, pharmIndex also reported 55 additional forms of these products which were introduced at the same time as the new products and 461 product changes (other than price) during 1962.

HOME DRUG REFERENCE GUIDE AVAILABLE FROM UPJOHN

A guide to help consumers choose drugs for complaints ranging from gastric distress to cuts and burns is available for free distribution by pharmacists in a new promotion developed by The Upjohn Company.

Called the "Home Drug Reference Guide," the pamphlet lists package sizes and correct dosages by ages for 16 different preparations, together with major characteristics and indications for use.

All of the drugs included can be bought without prescription. The pharmacist, therefore, may suggest that customers use the guide in selecting medications for every-day family needs, an Upjohn spokesman pointed out.

For gastric distress, for example, the guide suggests either Citrocarbonate, a well-known antacid effervescent salt, or Alkets, an antacid in tablet form, available with unbreakable dispenser for pocket or purse.

ACA ANNOUNCES MEETING SCHEDULE

Lee E. Eiler, President of the American College of Apothecaries has announced the meeting schedule for the College during the forthcoming year. As an affiliate of the American Pharmaceutical Association the A.C.A. will hold its Mid-Year Conference with the A.Ph.A. at the Hotel Americana in Bal Harbour, Florida, the week of May 12th.

The Annual convention of the College will be held in 1963 at the Greenbrier Hotel in White Sulphur Springs, West Virginia on October 27th through 30th.

NATION'S FIRST BLUE CROSS PREPAID Rx PILOT STUDY LAUNCHED

Associated Hospital Service, Inc. (Blue Cross) of Wisconsin has announced the nation's first Blue Cross pilot project offering a prepaid prescription plan, effective February 1, 1963.

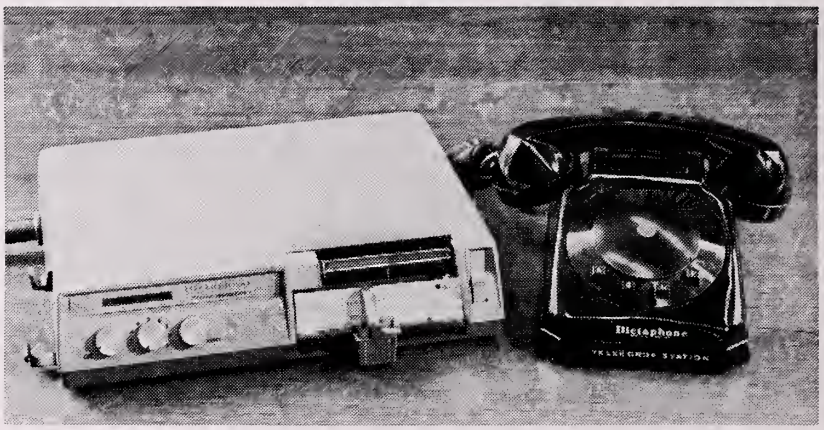
The one-year pilot plan will cover only Blue Cross employees and their families in Wisconsin, numbering

about 1,000. The program will be available to all Wisconsin pharmacists who offer, through their pharmacies, complete pharmaceutical services to the general public, and who agree to practice in accordance with the nationally-recognized Principles of Professional Pharmaceutical Practice. Participating pharmacists must sign an agreement with Blue Cross and claim reports must be turned in monthly to Blue Cross.

W. Allen Daniels, Executive Director of the Wisconsin Pharmaceutical Association, noted that "the pilot project offers Wisconsin pharmacists an opportunity to further patient service and relations and to implement the American Pharmaceutical Association Foundation's prepaid prescription study, which they have long supported."

In Washington, A.Ph.A. Executive Director William S. Apple reported that the "officers of the A.Ph.A. Foundation are most pleased that the Foundation's three-year study of prepaid prescription plans helped make possible this Wisconsin pilot project. The professsion hopes that after the necessary actuarial experience has been gained, Blue Cross will see fit to offer a prepaid prescription plan to Blue Cross subscribers throughout the nation."

Doctor, NOW You Can Dictate As Easily as Telephoning

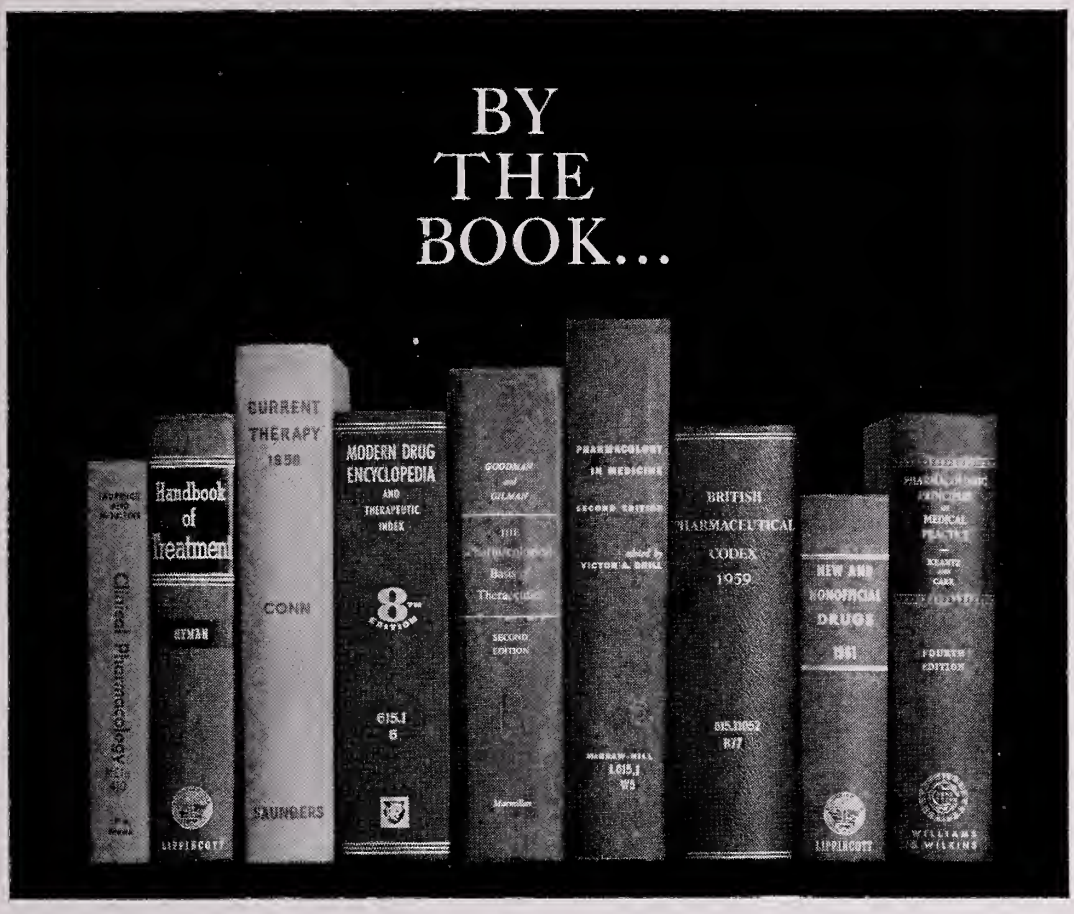


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PRO-BANTHĪNE P.A.® (Prolonged Acting) Tablets of 30 mg.
PRO-BANTHĪNE (*Half Strength*) Tablets of 7.5 mg.
PRO-BANTHĪNE® *with* DARTAL® Tablets, containing 15 mg. of PRO-BANTHĪNE and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).
PRO-BANTHĪNE *with* PHENOBARBITAL Tablets, containing 15 mg. of PRO-BANTHĪNE and 15 mg. of phenobarbital.
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they never even had a chance to complain about the cost of drugs

Walk through any older cemetery, and you will find the same ugly story repeated many times. Died, age 30 years... died, age 8 years... died, age 6 months.

Sometimes, you will see evidence of entire families being struck down almost simultaneously. You wonder, was it influenza? Diphtheria? Infectious diarrhea? Or a host of other diseases whose very names were synonymous with terror?
You will see, "Died, age 22—childbirth."

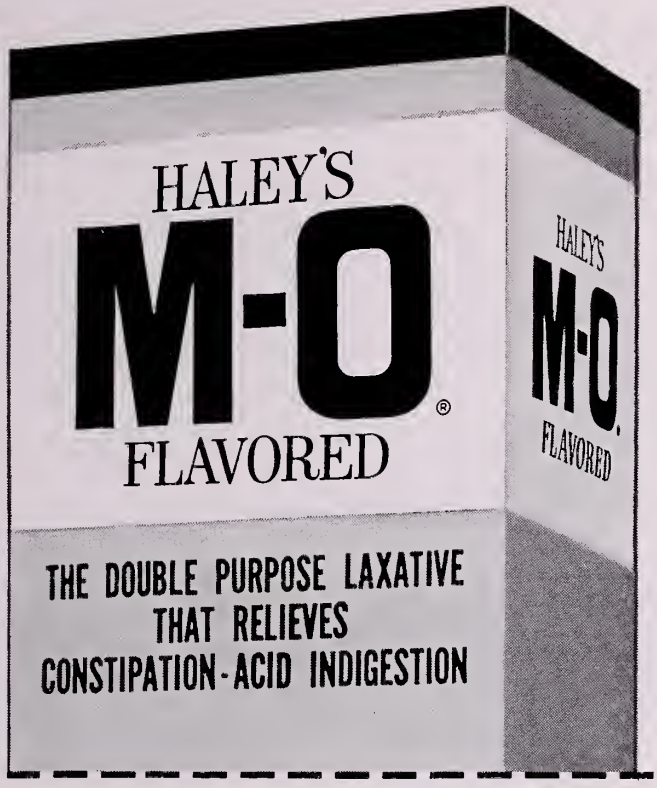
There are many reasons why you don't see a continuation of these tragic stories today—not the least of which has been the dedication of American physicians and the quality of medical education. And another, we sincerely believe, has been the quality of medicines which have been made available.

Yet, the value of independent drug research has been seriously challenged—research which has, in the past 30 years alone, helped to add nearly 10 extra years to the average lifespan in the United States. Yet, because the cost of the search must be reflected in the price the patient pays for a prescription, is it too expensive to continue? Unfortunately, perhaps those who might have the best answer can offer only silent testimony.

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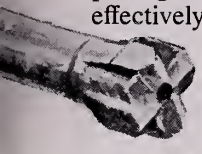
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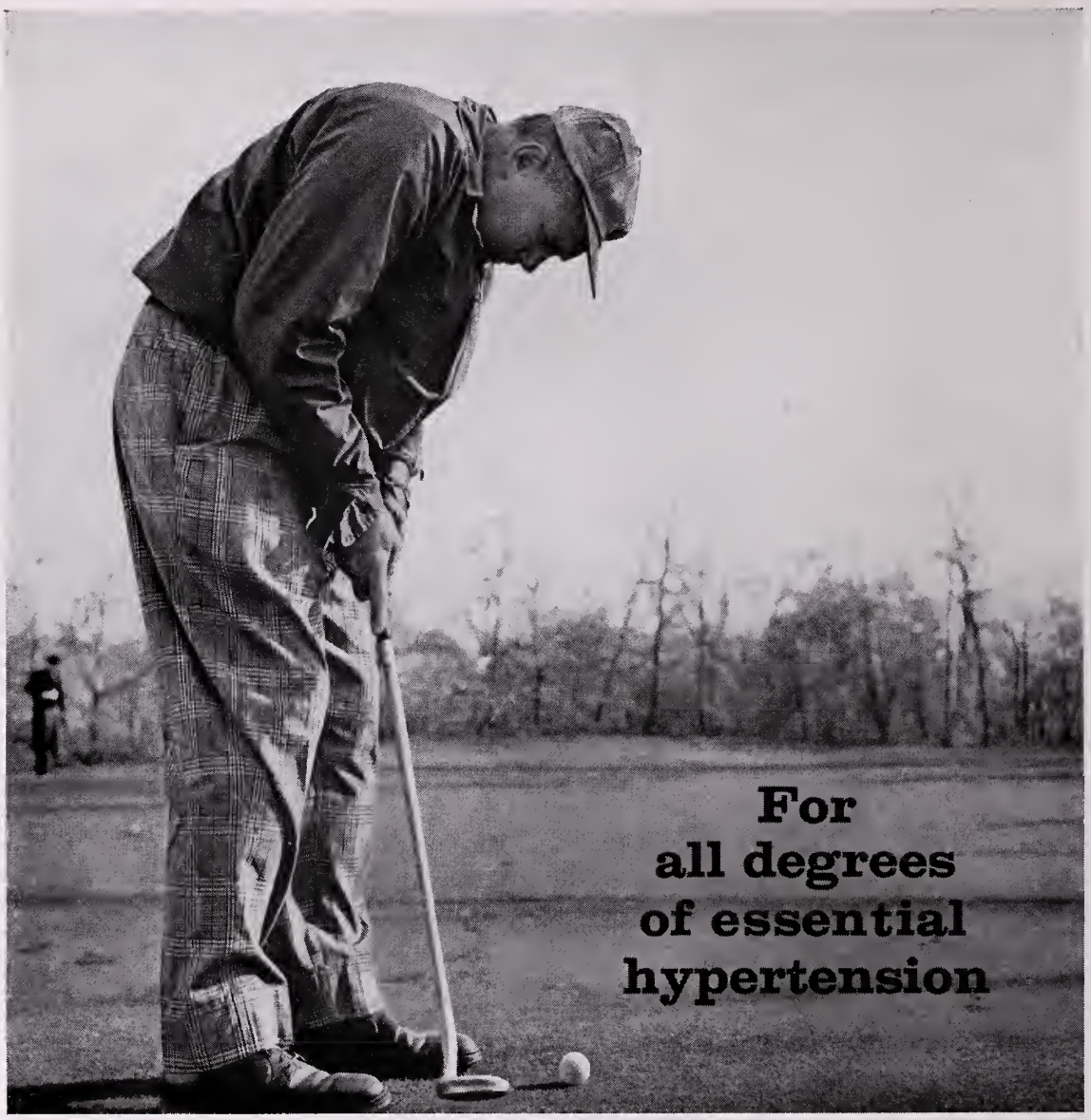
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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

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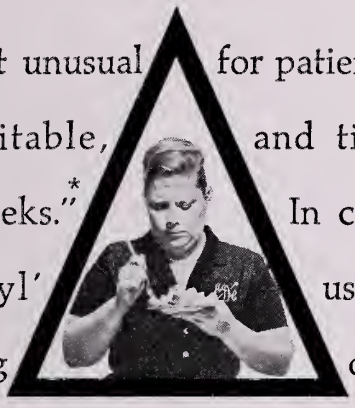
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Matlin, E.: The Obvious in Obesity, Clin. Med. 8:1071 (June) 1961.

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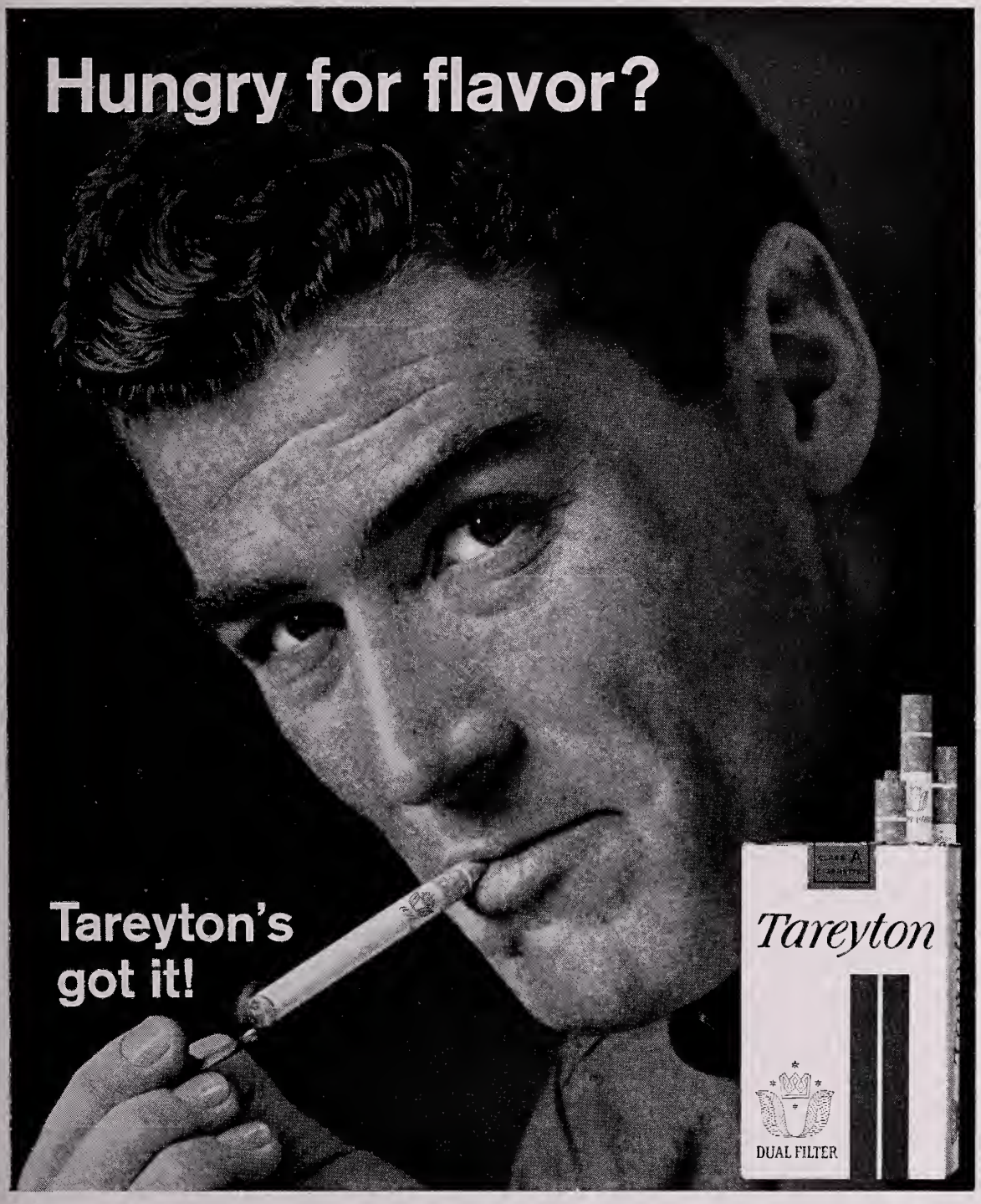
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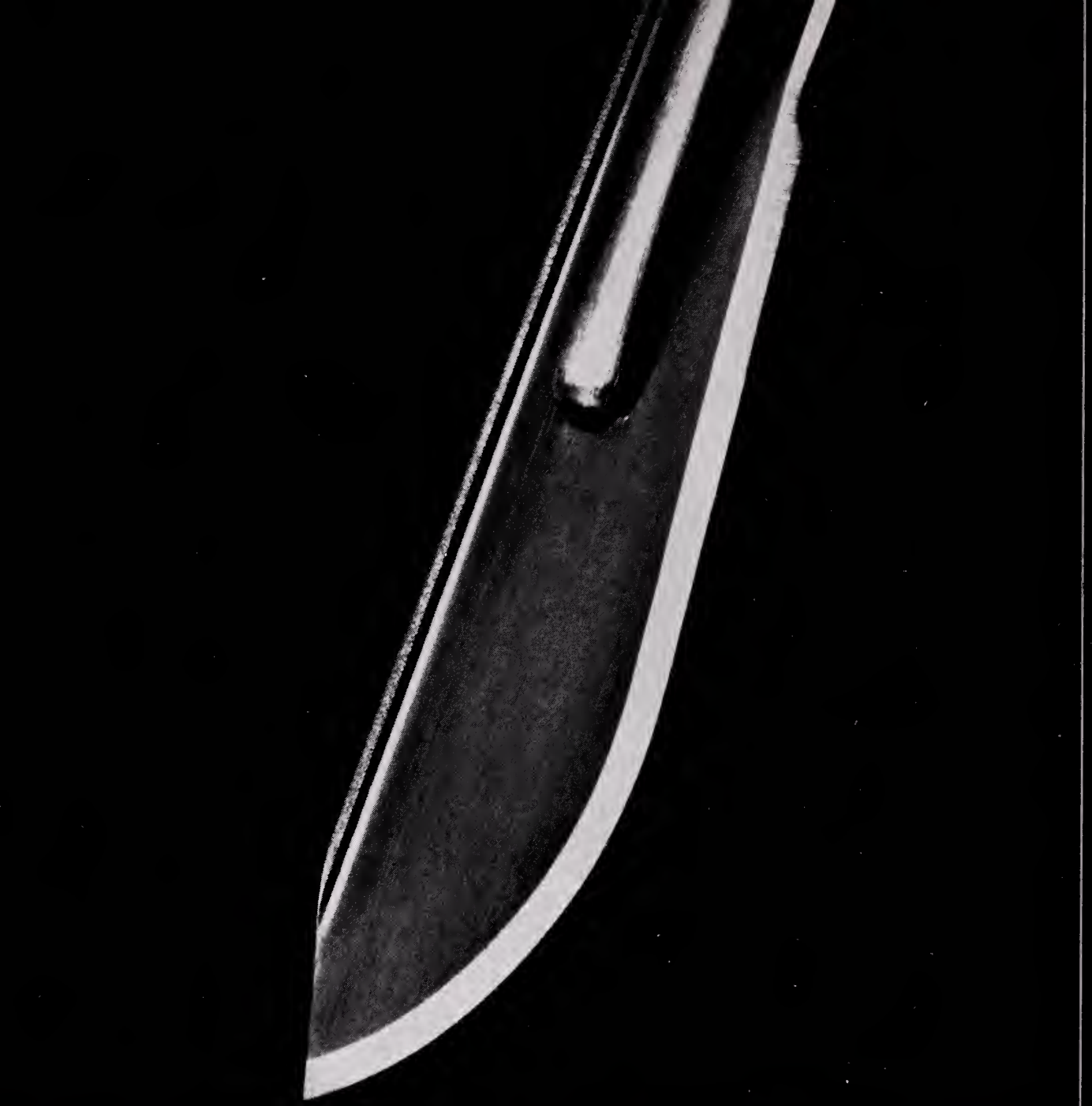
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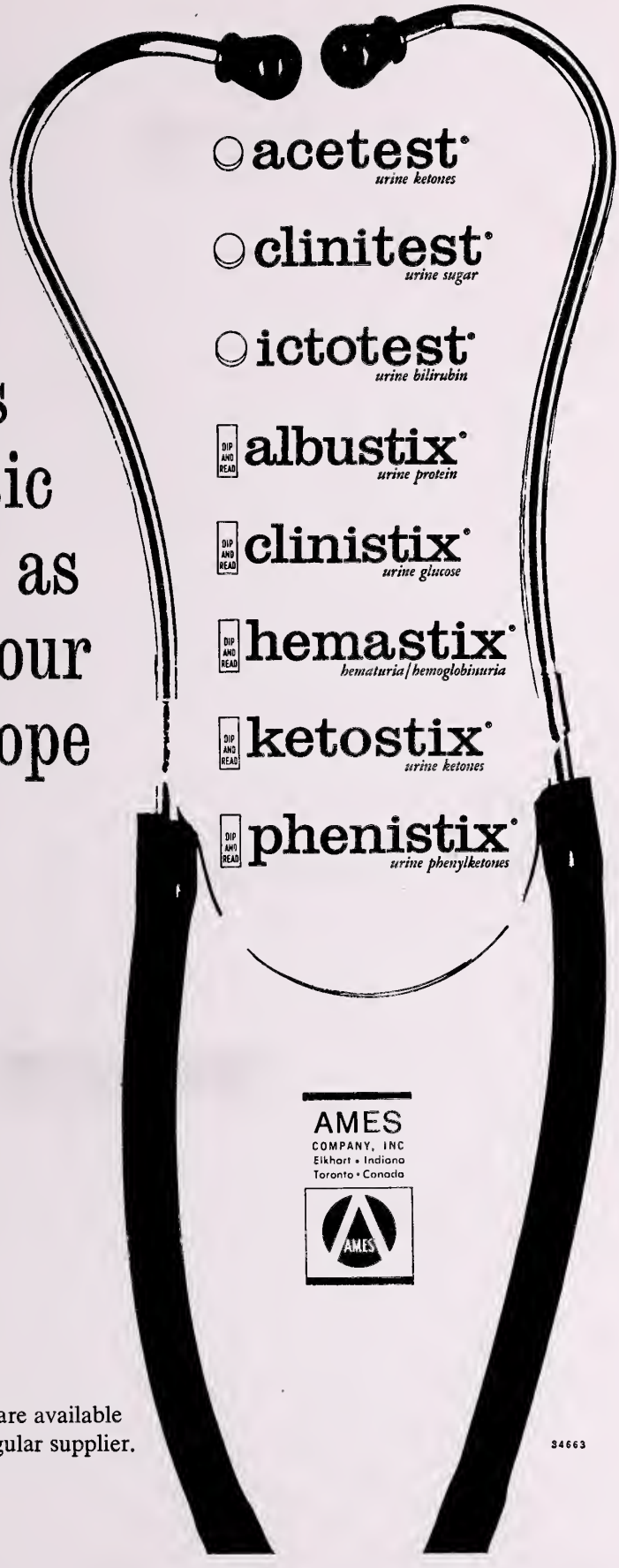
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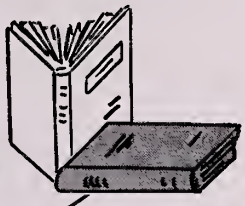
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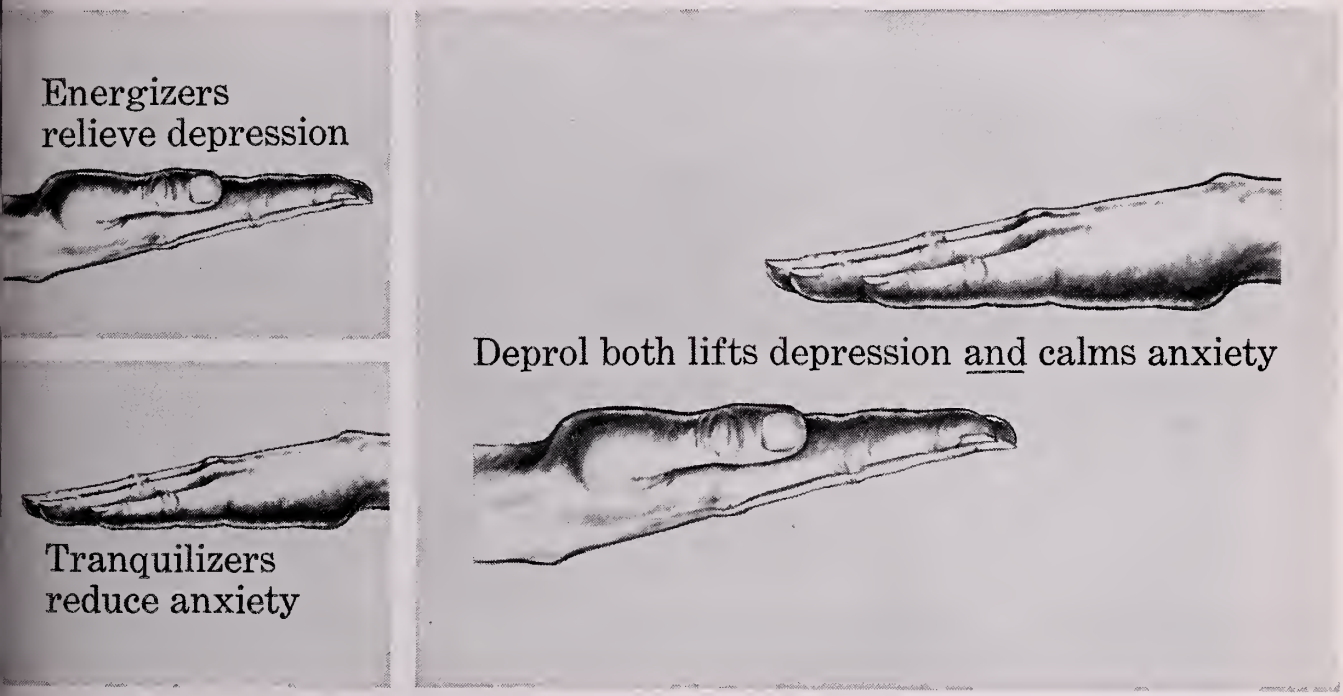
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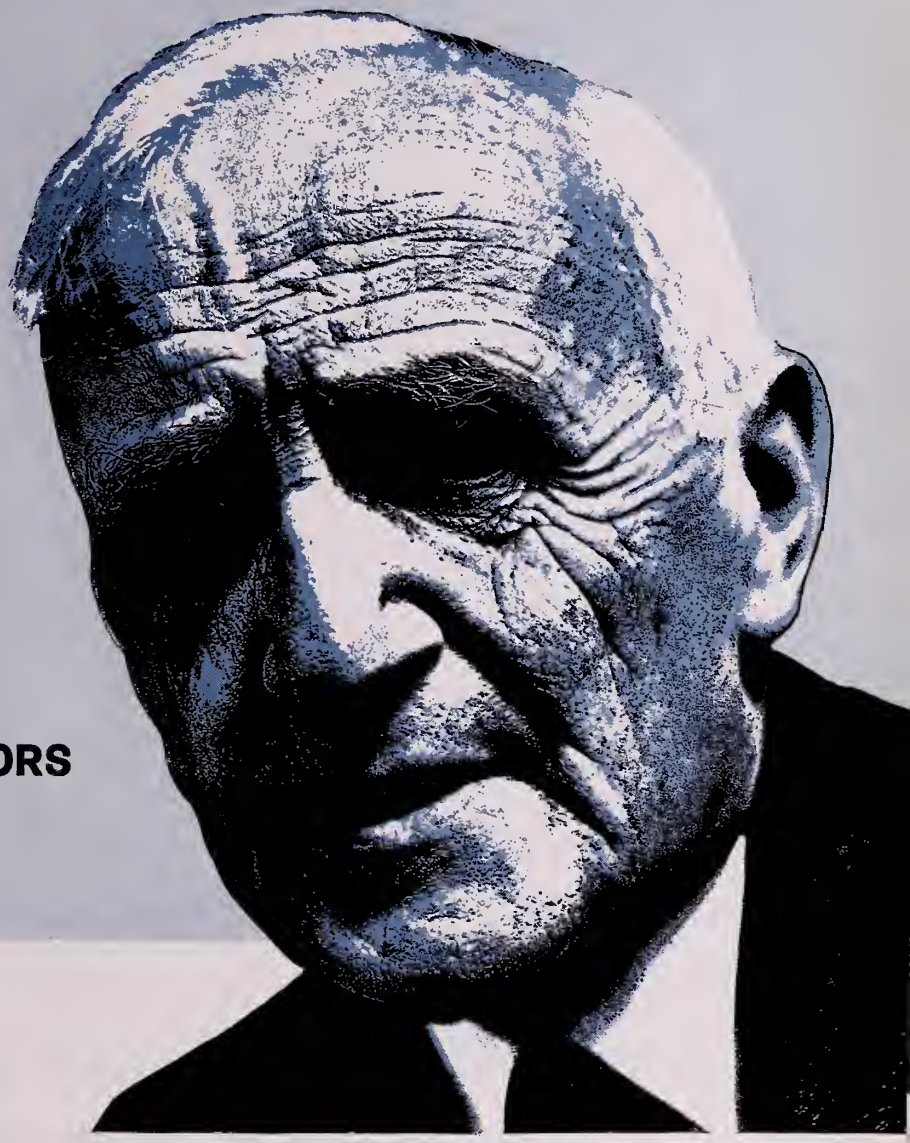
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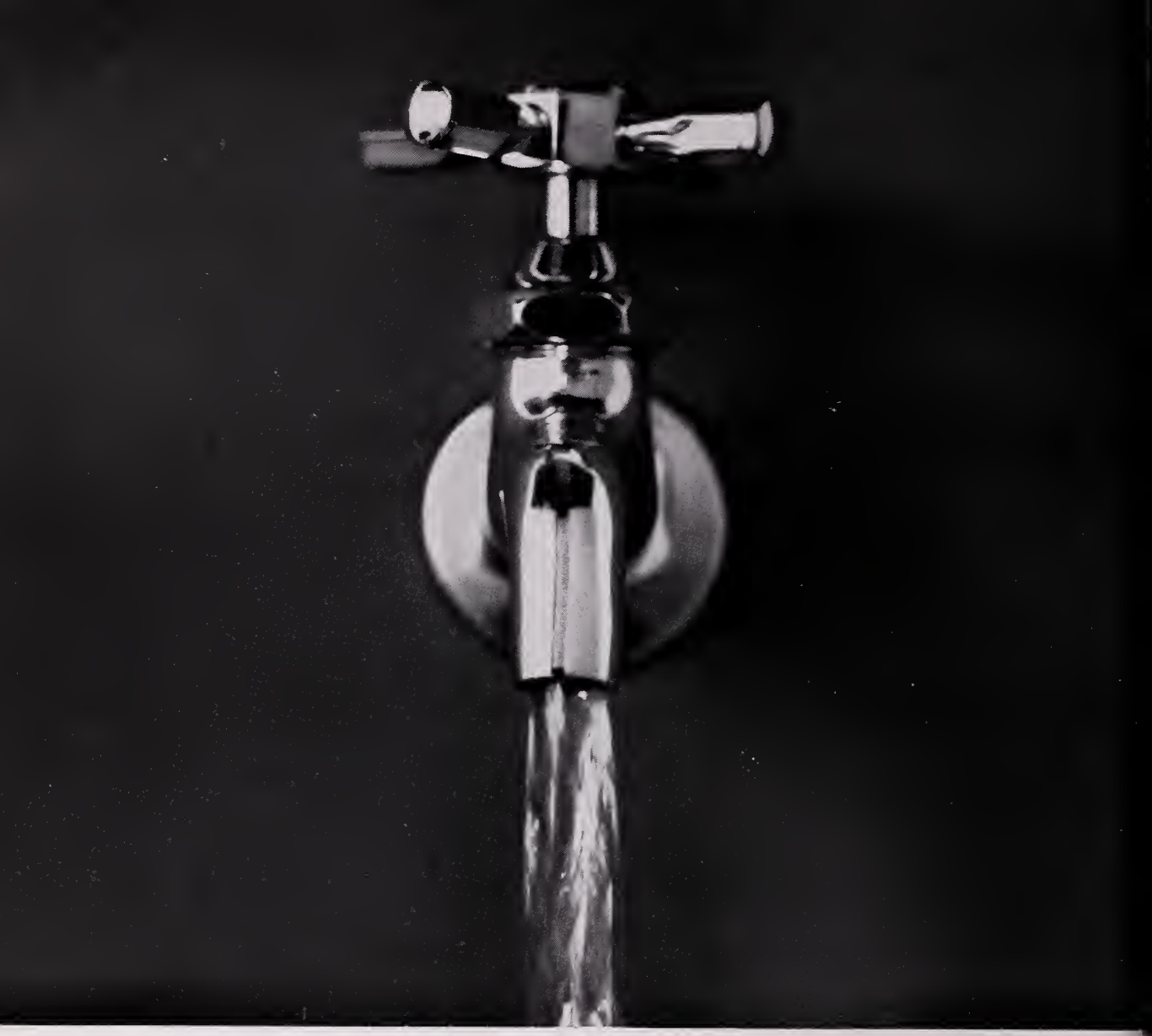
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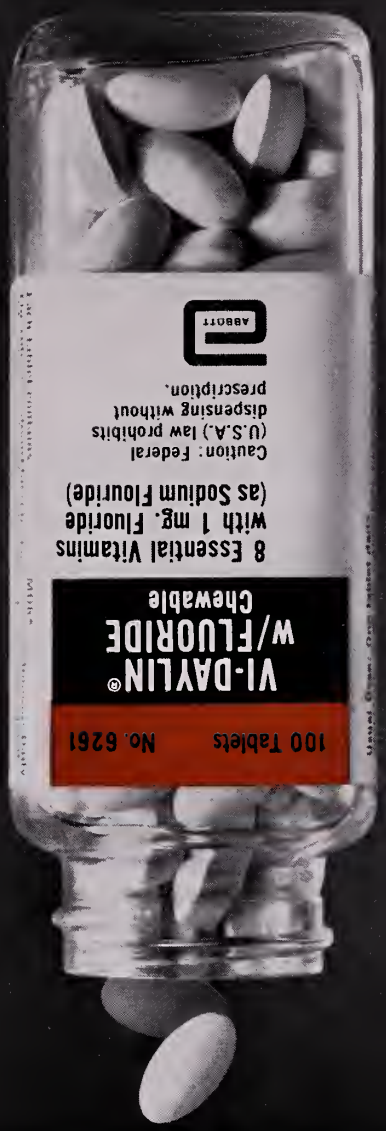
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1. Prescribing Supplements of Dietary Fluorides, Council of Dental Therapeutics, J.A.D.A., 56:591, April, 1958.
2. Fluoride Compounds, Accepted Dental Remedies, 27th Ed.:139, 1962.

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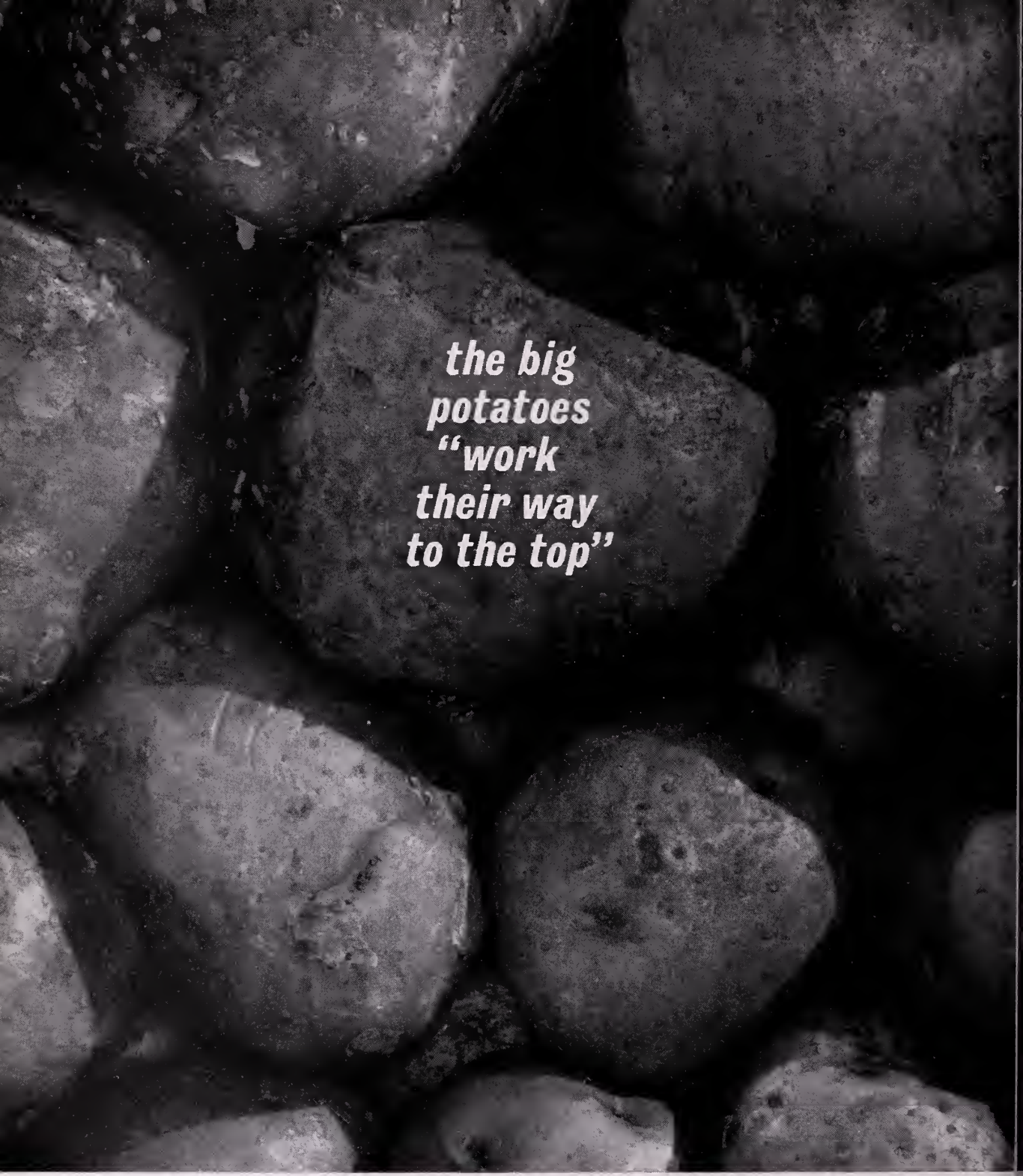
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DYSTOCIA DUE TO DISTENTION OF THE FETAL BLADDER

Report of a Case

C. RODNEY STOLTZ, M.D., F.A.C.O.G.

Watertown, South Dakota

A case of second-stage dystocia due to the distention of the fetal bladder is reported because of the rarity of such occurrences, especially in a case involving a term infant.

CASE REPORT

Mrs. R. W. (BC No. 6587), age 31, gravida 7, para 5, abortus 1, was first seen in this pregnancy, Sept. 15, 1960. Her L.M.P. had been on Feb. 10, 1960, and her E.D.C. was Nov. 17, 1960. She had been feeling well. Her menstrual history was not remarkable. Menarche was at age 12, and she had cycles of 28—31 days. The first four pregnancies were normal. The fifth ended in premature delivery of a 5-lb. infant; the sixth, in spontaneous early abortion with curettage.

The patient weighed 215 lb. and was 5 ft. 4 in. tall. She appeared normal except for obesity. Pelvic measurements were normal. Hemoglobin was 11.9 gm., U/A negative. She was AB-Rh Negative.

There were no unusual findings during the remainder of the pregnancy. On Nov. 21, 1960, the patient weighed 205½ lb. A mild secondary anemia responded well to iron therapy.

When admitted on Nov. 25, 1960, the patient had been in active labor for 8 hours. The cervix was 8 cm. dilated and completely effaced, Station 0, LOT. Amniotomy was done and a small amount of fluid escaped. Bearing down efforts with pains delivered the head without difficulty. The shoulders did not deliver. The arms could be felt and were delivered with only slight difficulty, thus delivering the shoulders and the child to the level of the axillae. At this point further de-

From the Department of Obstetrics and Gynecology, Bartron Clinic, Watertown, S. D.

livery was impossible, even with traction on the shoulder girdle assisted by fundal pressure from above. The efforts of both operator and assistant were of no avail in extracting the baby further. The child was alive when the head was delivered and took some gasping respirations, but expired in the 20 min. before further extraction could be accomplished. With the patient under general anesthesia the undelivered portion of the child was explored. On the abdominal side nothing definite could be felt except soft tissue. Posteriorly it was felt that one could reach the level of the child's iliac crests with no abnormality felt. A film of the abdomen of the mother revealed little except that the lower extremities of the child could be seen, thus ruling out gross abnormalities of the pelvis and lower extremities of the child. It was then felt that this must represent a soft-tissue dystocia. Consequently, an attempt was made to enter and explore the abdominal cavity of the child. The first scissors used were too short and the lower chest cavity was entered, which gave no further information. A longer scissors was obtained and the abdominal cavity was successfully opened. A cystic mass could be felt within the abdominal cavity of the child. This was decompressed by means of the scissors. A large amount of clear yellowish fluid escaped. Immediately upon decompression, the remainder of the child's body delivered without difficulty. The child was female. There was not a great amount of amniotic fluid noted following the extraction of the baby. It then became evident that the dystocia had been caused by the large abdominal mass. The abdomen of the fetus was further opened and the large mass was revealed to be a greatly distended urinary bladder which was at least 20 cm. and perhaps as much as 30 cm. in diameter before decompression. Some of the fluid from the distended organ was sent to the laboratory for identification. There were no vaginal lacerations. The placenta was removed manually without difficulty as it had separated and was lying free in the uterine cavity. At the termination of the procedure the patient was in good condition. The postpartum course of the mother was uncomplicated.

The fluid submitted to analysis was identified as urine. On autopsy the following conclusions were reported: Weight, 8 lb. 4 oz. Congenital obstruction of the urethra with hydronephrosis, renal insufficiency. Traumatic delivery of infant due to tremendously distended urinary bladder.

The significant findings were as follows:

"**Kidneys:** The kidneys are grossly atypical. The parenchyma is replaced by a thin shell of kidney surrounding cystically dilated calyces. Pelvic ureters and a massively enlarged urinary bladder are noted. The blood supply to the kidneys is unremarkable.

"**Urinary bladder:** The urinary bladder is markedly enlarged, thick walled and measures 4 cm. The lining mucosa is hemorrhagically congested and trabeculated. The urethral orifice is widely patent and on probing is patent as far as the external meatus. The external meatus shows a small dimple present which can be probed but again is plugged, leaving a narrow zone of fibrous connective obstructing tissue. The orifices of the ureters, although constricted, are patent and urine can be expelled through them into the bladder cavity. The bladder, at its apex, extends to the umbilicus but the duct is not patent.

"**Genitalia:** The genitalia are of the female type and are apparently attached to the under surface of the bladder structure."

DISCUSSION

All reported cases of dystocia due to congenital enlargement of the fetal urinary bladder, as far as can be determined, occurred in premature infants.[1-8] In some of the reported cases there was a urachial cyst[6] and in some there were associated congenital anomalies of the genitalia and lower bowel.[1-3] In most cases the child was male, although some had absence of the external genitalia.[1] However, the fetus in our case was female and showed no genital defects.

The capacity of the bladder has varied from 800 to 4200 cc.[7] in reported cases; in the present case the bladder capacity, although not accurately measured, was approximately 800—1000 cc.

This case supports the theory that the amniotic fluid is secreted by the amnion, as mentioned by Train, because of the normal amount of fluid noted at delivery and the grossly distended kidney pelves, with only a thin shell of parenchyma present, which

must have stopped functioning long before delivery.

When one encounters dystocia at the level of the shoulder girdle, as was the case here, one immediately thinks of polycystic kidneys, liver anomalies, and anomalies of the spine and lower extremities, but a grossly distended bladder must be considered.

SUMMARY

A case of second-stage dystocia due to the rare occurrence of distention of the fetal badder, and — even more rare — occurrence of this entity in a term infant, is reported.

320 7th Ave., S.E.
Watertown, S. D.

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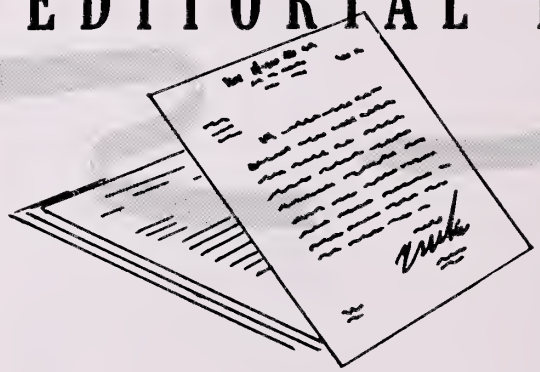
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EDITORIAL PAGE



RESUME OF SOUTH DAKOTA KERR-MILLS IMPLEMENTATION PROPOSAL

The 1963 Session of the South Dakota Legislature passed legislation to implement the Kerr-Mills Law in this State for medical care for needy persons 65 years of age and over.

The action of the legislature was unique in two ways, in that it provided only enough funds to conduct a pilot program, and it establishes a prepayment system of operation.

It was the feeling of the legislature that many states had jumped into a program without any accurate estimate of the total needs. Several of these have found that their appropriations far exceeded the demand for fund utilization.

A "pilot" program will determine within a short time, the number of needy persons, the extent of their needs, and will provide a more accurate determination of the cost of a full program.

The South Dakota State Medical Association took the position that any program for persons in the "near-needy" or "medically indigent" area should be treated as nearly akin to their more fortunate (and solvent) confreres as possible. Those persons having resources protect themselves against the cost of medical-surgical and hospital care with prepaid Blue Cross-Blue Sheild or insurance contracts so it was determined that persons who turned to the Kerr-Mills program as a resource should receive comparable benefits. The Legislative Committee studying the problem concurred in this view and a bill was drafted and introduced by Representative Ellen Bliss, Sioux Falls, Chairman of the House Committee on Health and Welfare.

The Bill was signed into Law by Governor Archie Gubbrud and becomes effective on July 1st or when the plan receives approval of the Department of Health, Education, and Welfare, whichever is later.

The Law empowers the State Department of Public Welfare to set up a program to qualify for Federal funds and provides that:

1. A person to be eligible for aid must not be a recipient of Old Age Assistance when he applies, must be unable to pay for medical or remedial care, must not have an average annual income of $1500 or more, or $1800 for a married couple, and must not have a net worth of $10,000 or more. If available funds are insufficient, the Department may set lower limits on income and resources but may not go above these specified limits.
2. The Department is empowered to accept applications and determine eligibility of those who apply. All individuals wishing to do so shall receive an opportunity to apply and assistance is to be furnished with reasonable promptness to those who are eligible.
3. The Department may appoint county advisory committees to assist in recommending selection of applicants. Basic

intent of this provision is to keep a local flavor to the selection where needs are best known.

4. The Welfare Department shall contract with Blue Cross and Blue Shield or licensed insurance companies to purchase prepaid health coverage which shall include the following:

   Hospitalization is to be limited to 30 days per admission in semi-private or ward accommodations. Said provision includes a $25.00 deductible clause, out-patient hospital care and services. Physicians services are limited to 12 office calls per fiscal year and to medical calls, surgical and other services in a hospital for 30 days per admission. Laboratory, X-ray and other special procedures may be limited to $100.00 per fiscal year. The latter procedures are subject to a $10 deductible clause. Physicians must agree in writing to participate in the plan.

5. A provision is made for the insurance company or Blue Cross-Blue Shield Plan to operate without profit or loss. A Contingency Fund was established to not only take care of the possibility of loss, but to provide services for individuals not on the program whose illness makes them eligible.

6. The usual provisions are included in the law which makes it effective simultaneously in all political subdivisions, prohibits payment by the recipient of enrollment fees as a condition of eligibility, reserves to the State Department of Welfare the right to cancel a contract within 30 days written notice, provides safeguards against use and disclosure of information concerning applicants for or recipients of assistance, and provides a penalty for fraudulent information given by the applicant.

The Program, as adopted by the Legislature, has the endorsement of the State Medical Association, the State Hospital Association, and other health organizations. The pre-payment aspect of the plan and the "pilot program" aspect of the plan which will curtail high administrative costs, met with high favor from most legislators and other individuals involved.

SWEET COMMENDATION

Once in awhile, the press notices some of the actions of the Medical Association and comments thereon. This item, reprinted from the Mitchell Daily Republic, applauds a recent action of the Association:

REALISTIC RESPONSE

We commend the **South Dakota Medical Association** for its quick and realistic response to the proposal by state representative Charles Lacey of Sioux Falls that a four-year medical school be constructed by South Dakota in Sioux Falls.

The medical association, through its spokesman John C. Foster, executive director, said it was standing by its position that a four-year school was not feasible in this state.

Rep. Lacey's words speak for themselves. He estimates that it would cost the state between $15 and $20 million to construct the school and around $2 million annually to operate it. The last figure is conservative to say the least.

South Dakota, on a population basis, is already pouring more money into higher education than any other state in the union. We have more state institutions of higher learning compared with our population than any other state.

Rather than seek new institutions and the resultant higher costs, this legislature should be looking into money-saving consolidations within our present colleges and into cooperative agreements for exchange of students with other states.

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AN ANALYSIS OF H. R. 10

By Jule M. Hannaford
Minneapolis Attorney
Counsel for NACM

On October 10 the President signed the Self-Employed Individuals Tax Retirement Act of 1962. It has been reported he signed it over the objections of the Treasury Department and only because he realized that if he vetoed it, its supporters had the votes to pass it over his veto.

The long and impressive name chosen for this Act does not accurately convey its significance. The Act stems from the more than 10-year campaign of professional men to gain tax equality for themselves in the retirement plan field through enactment of H. R. 10, commonly known as the Keogh-Smathers Bill. However, the Act that was signed by the President bears little resemblance to H. R. 10 as originally proposed.

A short history of this Act's stormy passage through Congress will be helpful in understanding the provisions of the Act as finally passed and may indicate possible future attitudes of the Treasury Department toward it and toward professional associations and corporations organized under state statutes passed in the last two years.

HISTORY

H. R. 10 originally was quite simple. It provided that each self-employed individual could deduct, in computing his income subject to federal income taxes, amounts deposited in a fund to provide retirement income for himself. The deduction for any year was limited to 10 per cent of an individual's net income or $2500, whichever was the smaller. There were certain provisions in H. R. 10 governing the use that could be made of the fund to make sure it was used for retirement, disability, or death benefits, but practically no other restrictions. In such form it passed the House in 1957 and again in 1959, in each case over the objections of the Treasury Department.

While these developments were taking place, developments were also taking place in a related field of tax law. Professional men — principally physicians — began to form unincorporated associations and claim such organizations should be taxed as corporations so that retirement plans could be adopted covering not only the employees of such organizations but also the associates. By the end of 1959 two court decisions had been handed down holding that physicians might do so, in each case again over the objections of the Treasury Department. The decisions to which I refer are the **Kintner** case and the **Galt** case.

Toward the end of 1959 the Senate Finance Committee requested the Treasury Department to present a substitute for H. R. 10 which would grant the self-employed some tax equality and would be acceptable to the Treasury. Following receipt of this request the Treasury took two steps. First, it issued proposed regulations designed to prevent

most unincorporated associations from being taxed as corporations. Second, it submitted a substitute for H. R. 10.

In its substitute the Treasury stated that it objected to H. R. 10 in its original form because it permitted the self-employed to make contributions to retirement plans for their own benefits without making comparable contributions for the benefit of their employees. This, the Treasury said, would create a precedent for allowing individuals to take tax deductions for sums set aside for retirement, even though historically such favorable tax treatment had been allowed only in the case of non-discriminatory plans for the benefit of employees. The Treasury feared that, on the basis of such precedent, executives and union members would ask for a tax deduction for sums they set aside for their retirement. Accordingly, the Treasury proposed that the self-employed should not be granted the benefits of H. R. 10 unless they established retirement plans covering their employees on some sort of a non-discriminatory basis and with appropriate safeguards.

If the Treasury had stopped its proposal for an alternative to H. R. 10 at this point, the Act would probably have passed in 1960. Unfortunately, the Treasury went further and made three additional suggestions for change in the then existing tax laws which would have had adverse effects on then existing retirement plans of corporations.

First, the Treasury took the position that an owner-manager of a corporation (a term subsequently defined as one who owns more than 10 per cent of the voting stock of a corporation) should thereafter be treated the same as a self-employed person and that retirement plans adopted by corporations which had an owner-manager should be subject to all the restrictions applicable to retirement plans adopted by the self-employed. This would have meant, for example, that a corporation could not contribute to its retirement plan on behalf of an owner-manager more than $2500 per year.

Second, the Treasury took the position that the capital gains treatment for lump sum distributions from retirement plans was not justified and should not be available either for retirement plans of the self-employed or for retirement plans of corporations.

Third, the Treasury took the position that the exemption from the federal estate tax of sums paid from retirement plans to heirs of a deceased employee was not justified and should not be available either for retirement plans of the self-employed or for retirement plans of corporations.

The Senate Finance Committee reported H. R. 10 to the Senate on June 17, 1960, with an amendment making the Treasury's first proposal applicable to all retirement plans and the Treasury's second and third proposals applicable to retirement plans for the self-employed. Largely because of the opposition that developed to the Treasury's first proposal, H. R. 10 was not brought up for consideration by the whole Senate before Congress adjourned in the fall of 1960.

At this point in time the Treasury did not have a law severely restricting the right of the self-employed and of corporations with a 10% stockholder to adopt retirement plans and it was being besieged by requests from unincorporated associations and partnerships to adopt retirement plans covering partners and associates. As a result it issued in final form on November 15, 1960, the now famous or, if you prefer, infamous Kintner regulations. They were artfully drafted to prevent most unincorporated associations and partnerships from adopting retirement plans covering associates or partners — apparently in an attempt to forestall such action by unincorporated associations and partnerships of professional men at least until the Treasury's substitute for H. R. 10 could be passed and the law would severely restrict their freedom of action.

When the 87th Congress convened in January 1961, H. R. 10 was promptly reintroduced. The House Ways and Means Committee acted favorably on the bill in May 1961 and the Senate Finance Committee in September 1961. Both the House and Senate Committee versions of the bill made the three Treasury Department proposals mentioned above applicable only to retirement plans covering the self-employed. Neither Committee tried to make the proposals applicable to corporate retirement plans.

H. R. 10 again passed the House in the summer of 1961, but the first session of the 87th Congress adjourned that year before it could be brought before the whole Senate. It did

not come before the Senate for consideration until early in September 1962. At that time Senator McCarthy proposed an amendment which restricted contributions to corporate retirement plans for the benefit of an owner-manager to $2500 per year and Senator Gore proposed amendments which eliminated the capital gains treatment and estate tax exemption for distributions from all retirement plans. These amendments, which embodied the three Treasury proposals, were adopted on the floor of the Senate before H. R. 10 was finally passed by the Senate on September 7, 1962.

The opposition that developed to these amendments of Senator McCarthy and Senator Gore was tremendous and in the conference between the House and Senate they were eliminated. As a result, none of the Treasury's proposals and none of the other restrictions apply to corporate retirement plans in the Act as repassed by both Houses and finally signed by the President on October 10, 1962; they apply only to retirement plans of the self-employed.

EFFECTIVE DATE

H. R. 10 is effective only with respect to taxable years beginning after December 31, 1962. Clinics on a calendar year basis will not, therefore, be able to take advantage of the law until 1963. Clinics on a fiscal year basis will not be able to take advantage of the law until the start of their first fiscal year beginning after December 31, 1962. For clinics with a September 30 closing, for example, this will mean they cannot take advantage of the law until October 1, 1963.

THE PROVISIONS OF H. R. 10

H. R. 10 has created three categories of qualified retirement plans. The first is one covering plans adopted by corporations and organizations eligible to be taxed as corporations. The second is one covering plans adopted by a partnership or an unincorporated organization in which no partner or owner has more than a 10% interest in the assets or the profits of the organization. The third is one covering all other unincorporated organizations. The second and third categories are new ones that have been created by H. R. 10. These two new categories draw a distinction between big and small unincorporated organizations. All partnerships with nine or less partners will have a partner who has more than a 10% interest and will, therefore, fall into the third category. Only a partnership with ten or more partners can possibly qualify in the second category as a firm in which no person has more than a 10% interest in the assets or profits. This distinction between large and small unincorporated organizations is not merely one of terminology. The substantive provisions of the law differ depending on the category into which an organization falls. Corporations receive more favorable treatment than partnerships and large partnerships receive more favorable treatment than small partnerships. The discrimination against the self-employed still remains and it is particularly severe for the small partnerships.

Perhaps the best way to understand the restrictive provisions of H. R. 10 is to look at the requirements imposed by law upon retirement plans and compare how these requirements differ from category to category.

COVERAGE. The number of persons covered by a retirement plan has an important effect upon its costs. The law for years has required that employees must be covered on a non-discriminatory basis but the rules against discrimination have not been too hard to live with.

Plans adopted by corporations have traditionally been permitted to exclude from coverage part-time and seasonal employees — those who work less than 20 hours a week or 5 months a year. This right is also granted by H. R. 10 to both large and small partnerships.

Plans adopted by corporations also have traditionally been permitted to exclude from coverage employees with less than 5 years of service and those who have not reached a particular age. Many corporate plans, for example, require for eligibility 5 years of service, plus the attainment of age 30 for males or age 35 for females. By adopting such provisions a corporation may cut down its coverage substantially and thereby reduce the costs of its retirement plan. Corporations may continue to use such eligibility tests. Large partnerships without a 10% partner may also do so. However, small partnerships which have a 10% partner may not do so. They will be required to cover all employees with 3 years or more of service and will not



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be able to exclude employees with 3 or more years of service who have not reached some minimum age. As a result, small partnerships which wish to adopt a plan covering their partners will in most cases have to cover a larger percentage of their employees than do large partnerships or corporations.

Corporations also have traditionally been permitted to limit the coverage of their plans by excluding from coverage hourly paid workers and by covering only salaried employees. This device for limiting coverage will be available to corporations and to large partnerships who do not have a 10% partner. However, a small partnership which has a 10% partner will not be able to use this device to exclude from coverage anyone who has 3 or more years of service. This rule will also force small partnerships to cover a larger percentage of their employees than large partnerships or corporations.

One point in connection with such means of limiting coverage should be borne in mind. If a group desires to adopt a years of service test for eligibility, the test must apply to both partners and employees. A group will not be permitted to adopt a rule requiring for eligibility 3 years of service by an employee and 1 year of service by a partner. However, there is no prohibition against counting for the purpose of establishing eligibility for either partners or employees years of service with the partnership prior to the passage of H. R. 10. The same result would not ensue were a group to reorganize under one of the professional association or corporation acts. If a group were to do so, the years of service with the prior partnership could be counted by employees for the purpose of establishing eligibility but could not be counted by partners for this purpose. Thus, groups who reorganize under professional association or corporation acts will not be able to adopt a years of service test for eligibility unless the physicians who were formerly partners are willing to wait for coverage of themselves until they have served a probationary period as employees of the professional association or corporation.

There is another requirement with respect to coverage that applies to a small partnership with a 10% partner. If a partner or a group of partners in such a partnership owns more than a 50% interest in the capital or profits of another partnership, the first partnership cannot adopt a plan covering its partners unless the second partnership also adopts a plan covering its employees and the plan provides for the employees of the second partnership benefits as favorable as those provided for the employees of the first partnership and its partners. This provision will prevent a small medical group from excluding its non-professional personnel from coverage by forming two partnerships — one of which practices medicine, and the other of which owns the equipment, employs the non-professional personnel and makes both available to the first partnership for a fee. Whether the result would be the same were the second firm a corporation rather than a partnership is uncertain.

One final provision with respect to coverage should be mentioned. If a small partnership adopts a retirement plan, no contribution or benefit may be made or provided for a 10% partner unless he consents thereto. As a result, a small partnership will be able to allow each partner who has more than a 10% interest in the capital or profits to decide whether or not he wishes to be covered under its plan. The Act contains no comparable provision for partnerships which have no 10% partner. If any such partnership desires to adopt a plan covering any partner, I am afraid it will have to cover all partners on a non-discriminatory basis and will not be permitted to allow each partner to decide whether or not he wishes to be covered.

VESTING. **Vesting** is a convenient word used to describe what happens to contributions made to a qualified retirement plan for an employee who quits or is discharged prior to his normal retirement date. It is not uncommon to provide in retirement plans that such an employee forfeits all or a part of what has been contributed for him unless he has been employed a specified number of years. For example, a plan might provide that an employee who quits or is discharged before he has been under the plan one year takes nothing with him, and that for each year of coverage under the plan in excess of one he takes 10% of the contributions made for his benefit. Forfeitures resulting from such a provision can amount to a considerable sum of money where a firm has a large number of women employees who normally

quit when they get married or pregnant. Such sums can be used to considerable advantage in the case of both pension and profit sharing plans to reduce future contributions by the employer or, in the case of profit sharing plans, to increase the benefits for those employees who remain until normal retirement date. Corporations and large partnerships which do not have a 10% partner are free to adopt such vesting provisions if they so desire. However, small partnerships with a 10% partner must provide in their plans that contributions for their employees are non-forfeitable when made. H. R. 10 does contain a provision that the Secretary of the Treasury by regulations may relieve small partnerships from this provision if appropriate provision is made to prevent forfeitures from accruing to the benefit of partners and highly compensated employees. When the Secretary of the Treasury will get around to issuing such regulations, no one can tell.

While these requirements for vesting may increase costs for small groups, they probably are not very different from those most clinics would end up with if they were free to adopt a plan without reference to the provisions of H. R. 10. Most partners would object to a provision in a plan stating that if they resigned from the partnership, they are not entitled to 100% of what has been contributed to a retirement plan for their benefit. Under the law as it existed prior to the passage of H. R. 10, contributions for all employees had to be non-forfeitable when made, if they were non-forfeitable for any employee when made. Therefore, if partnerships had been allowed to adopt retirement plans covering partners before the passage of H. R. 10, I am sure that most such plans would have provided contributions for everyone are fully vested when made.

INTEGRATION. Another way to cut down the cost of a retirement plan and to have a large percentage of the employer's contributions provide benefits for highly paid employees is to integrate it with social security. While integration is a complicated matter, basically it means that benefits, both from the retirement plan and social security, are uniformly proportionate to salary. Under an integrated plan, an employer may elect to make no contributions with respect to the first $4800 paid to each employee — the amount subject to social security tax — provided the benefits payable on that part of an employee's salary over $4800 do not exceed certain limits. Corporations and large partnerships with no 10% partner may adopt integrated plans provided they meet these traditional requirements for integration. In addition, H. R. 10 allows medical partnerships to assume that their physician-partners are subject to social security for the purpose of meeting the traditional requirements of integration. Small partnerships with a 10% partner will, however, be permitted to adopt integrated plans only if they meet requirements more strict than the traditional ones and in addition only if not more than 1/3 of each annual contribution is made for the benefit of 10% partners. This additional requirement means that small partnerships will have less freedom of action when using integration in an attempt to maximize contributions for the benefit of physicians.

CONTRIBUTIONS BY EMPLOYER. A corporation may contribute to a pension plan so much as is necessary to pay the cost of the plan, to a profit sharing plan up to 15% of the payroll of the covered employees, and to a combined pension and profit sharing plan up to 25% of the payroll of the covered employees.

These rules limiting corporate contributions have not been changed and will apply to contributions by partnerships for the benefit of their employees. They will also apply to partnership contributions for the benefit of persons who are not 10% partners. But for persons who are 10% partners, no more than the lesser of 10% of earned income or $2500 may be contributed annually and, if a person is a 10% partner in two firms, the limitation applies to the aggregate of the two contributions made by both firms on his behalf. Earned income to which the 10% limitation on contributions applies is, in the case of a physician, his share of the partnership's net income. Earned income does not include sums received as rent, interest, or dividends.

A corporation is allowed to deduct in computing its income subject to federal taxes the entire amount it contributes to a qualified retirement plan so long as the contributions are within the over-all limits set forth above. Both large and small partnerships may do

likewise with respect to contributions on behalf of employees. However, a partnership, whether large or small, may deduct with respect to a contribution made on behalf of a partner only 50% of the contribution or $1250, whichever is the smaller.

From the foregoing it can be seen that if a partnership adopts a plan calling for an annual contribution of 10% of salary or earned income of all covered employees and partners, it may contribute for a partner whose earned income is $30,000 a year $3000 if he is not a 10% partner, but only $2500 if he is a 10% partner. But no matter what the contribution may be, the firm may not deduct more than $1250 in any year.

One further point with respect to employer contributions should be mentioned. Not only must they be non-discriminatory as between employees and partners, but also they must be non-discriminatory between partners. In other words, it will not be possible to let each partner decide what percentage of his earned income will be contributed to a retirement plan for his benefit. The contribution will have to be computed on the same basis for each partner (except for 10% partners who elect not to be covered) and cannot be more favorable to partners than to employees.

CONTRIBUTIONS BY EMPLOYEES. Contributory retirement plans under which the employee contributes part of the cost of the benefits are not uncommon. Employee contributions under such plans are not, of course, deductible in computing the employees' income taxes. There are certain restrictions on such employee contributions to corporate plans to insure that top executives will not contribute a greater percentage of salary than lower paid employees. Partners in large partnerships will be subject to these rather innocuous restrictions. However, partners in a small partnership will be prohibited, in addition, from contributing in any year more than the lesser of $2500 or 10% of their earned income.

PLAN ADMINISTRATION. A corporation can name anyone it wants to act as trustee of its retirement plan. A large partnership with no 10% partner may do likewise. However, a small partnership with a 10% partner must name a bank as trustee, except in cases where the fund is invested exclusively in annuity, endowment, or life contracts, in cases where the fund is invested exclusively in mutual funds and a bank is named as custodian to hold the securities, and in cases where the fund is invested in a new type of government bond authorized by H. R. 10.

It is not uncommon for retirement plans to invest in insurance contracts. A type of policy frequently used is one providing $1000 of life insurance for each $10 of retirement income provided. If a corporation's plan invests in insurance contracts of such a nature, it gets a deduction for sums used to pay premiums on the insurance contracts, but the persons on whose lives the insurance contracts are purchased must include as income an amount equal to the cost of providing a comparable amount of term life insurance. This same rule will apply when partnerships buy insurance contracts of such a nature for their employees. However, if a partnership, whether large or small, causes its plan to buy insurance contracts of such a nature for its partners, the amount of its contribution allocated for such purpose is not deductible in computing the partners' federal income taxes.

One advantage that some medical groups have hoped to obtain from a retirement plan is to have the plan eventually own the groups' building. If this is done, new partners will be able to buy in and deceased or retired partners can be bought out at substantially lower prices. There are no prohibitions against a plan owning a clinic building whether the group be a corporation, a large partnership, or a small partnership. There are, however, restrictions on a plan's right to purchase such building from the group or a building corporation owned by the group. Plans established by small partnerships may not do so under any circumstances and those established by large partnerships and corporations may do so only if they pay a fair price for the building.

DISTRIBUTION DATES. Under corporate retirement plans the trustee is usually given board direction to determine the method of distribution best suited to each individual's needs. Such discretion is severely limited in connection with distributions to partners in big and small firms. In the case of a partner who does not have a 10% interest, his entire interest must be distributed to him not later than the year in which he becomes 70½ or

the year in which he retires, whichever is later. In the case of a 10% partner, his entire interest must be distributed to him not later than the year in which he becomes 70½. The Act authorizes the issuance of regulations permitting installment payments beginning on such dates and continuing over a period not extending beyond the life expectancy of the partner or the partner and his wife.

The Act also requires plans to provide that no benefit may be paid to a 10% partner prior to the time he reaches 59½, except in case he becomes disabled. This will prevent distributions to 10% partners for emergency purposes, on early retirement or on termination of the plan unless such partner has reached 59½ years of age.

INSTALLMENT DISTRIBUTIONS. If an employee covered by a corporate plan to which he has not contributed receives installment payments over a period of years, the entire amount of each distribution is taxable as ordinary income. Partners in both big and small partnerships will receive more favorable treatment. Since only half of their annual contributions will have been deductible in computing their income taxes, they will have paid out of tax paid income for half of what they receive. Therefore, in most cases only half of each installment will be taxable income to a partner or other self-employed person.

LUMP SUM DISTRIBUTIONS. A beneficiary of a corporate retirement plan who is paid his entire interest under the plan in the year in which his employment is terminated by retirement or otherwise may treat the sums so received as capital gains. This rule for corporate employees remains the same and it will apply to employees of partnerships. The tax treatment of lump sum distributions to a partner whether of a big or small firm is quite different. In any year in which a partner receives a lump sum distribution, he computes what his additional tax would be if he added 1/5 of the distribution to his taxable income. The tax that he must actually pay is 5 times the additional tax so computed. This rule is subject to certain limitation designed to prevent a partner from escaping tax on such distributions by making charitable contributions or other expenditures that are deductible in computing his personal income taxes.

This rule for the taxability of lump sum distributions to partners may not be as burdensome as it sounds at first blush and may even give partners an advantage over corporate employees in some situations. In the first place it only applies to so much of a lump sum distribution as is attributable to contributions made while he was a partner. So much of such a distribution as results from contributions made while a person was an employee, prior to becoming a partner, is still eligible for capital gains treatment. In the second place, half of most distributions to a partner will not be taxable income in any event as it has been purchased with tax-paid dollars — the half of each annual contribution which is not deductible.

ESTATE TAXES. Distributions from a corporate retirement plan made after an employee's death to his heirs (but not to his estate) are not considered part of such employee's estate for federal estate tax purposes except to the extent he has contributed to the cost thereof. Well-to-do executives have often reduced estate taxes by leaving intact until their deaths sums accumulated in retirement plans for their benefit and by living off other assets following retirement.

The Act provides that this exemption from estate taxes is not available to partners of either large or small firms.

OTHER FRINGE BENEFITS

Not only does H. R. 10 discriminate against the self-employed with respect to retirement plans for their benefit, it also discriminates against them with respect to other fringe benefits. Among the fringe benefits that are available to corporate employees are the following:

1. Insurance programs providing group life insurance, group accident and disability insurance, or group health insurance can be established for all employees. Premiums paid for such insurance are deductible when computing a corporation's federal income taxes and will not be taxable income to the employees.

2. A plan can be established providing for payments to employees who become sick or disabled. If such a plan is adopted, the payments to the employees will be deductible in computing the corporation's federal income taxes and up to $100 per week may be ex-

cluded by each employee in computing his income subject to federal income taxes.

3. On the death of an employee up to $5000 may be paid to the widow, estate, or designated heirs of an employee, and such sum will be deductible in computing the corporation's federal income taxes but will not be taxable income to the recipient.

H. R. 10 contains specific provisions to make it clear that if a partner in a partnership, whether large or small, or his heirs receives either type of payment referred to in paragraphs 2 or 3 above, the sums so received constitute taxable income. While the Act does not specifically provide that a partnership will not be able to pay premiums on life, health, and accident insurance taken out for the benefit of a partner and deduct the premiums paid in computing federal income taxes, and that the partner will have to include such premiums in his taxable income, I believe the Treasury will try to interpret the law so as to reach that result. The contrary result in the case of health and accident insurance would not in any event be of much help to partners, for while payments received under such policies are not taxable income if the recipient has paid the premiums, such payments are taxable income to the recipient if his employer has paid the premiums thereon and if the payment does not come under a plan of the type described in paragraph 2.

THE VERDICT FOR H. R. 10

H. R. 10 is a step in the direction of providing tax equality for the self-employed. But it is only a step and not a very big one. From what has been said it seems obvious that any medical group desiring to establish a retirement plan will be better off from a tax point of view if it incorporates than if it proceeds under H. R. 10; **provided,** of course, the Treasury will permit it to be taxed as a corporation. The provisions of H. R. 10 outlined below placing restrictions on retirement

Without any Plan		With H. R. 10 Plan		With Corp. Plan	
		Net income	$16,000	Net income	$16,000
		Less contribution	1,600	Less contribution	1,600
1. Taxable income	$16,000		14,400		14,400
Federal income taxes	3,920	Federal inc. taxes	3,680	Federal inc. taxes	3,440
Spendable inc.	12,080	Spendable inc.	$10,720	Spendable inc.	$10,950
		Tax savings	$240	Tax saving	$480
		Net income	$25,000	Net income	$25,000
		Less contribution	2,500	Less contribution	2,500
2. Taxable income	$25,000		22,500		22,500
Federal income taxes	7,230	Federal inc. taxes	6,705	Federal inc. taxes	6,230
Spendable inc.	17,770	Spendable income	$15,795	Spendable income	$16,270
		Tax saving	$525	Tax saving	$1,000
		Net income	$35,000	Net income	$35,000
		Less contribution	2,500	Less contribution	3,500
3. Taxable income	$35,000		32,500		31,500
Federal income taxes	11,900	Federal inc. taxes	11,275	Federal inc. taxes	10,165
Spendable inc.	23,100	Spendable income	$21,225	Spendable income	$21,335
		Tax saving	$625	Tax saving	$1,735
		Net income	$45,000	Net income	$45,000
		Less contribution	2,500	Less contribution	4,500
4. Taxable income	$45,000		42,500		40,500
Federal income taxes	17,340	Federal inc. taxes	16,620	Federal inc. taxes	14,800
Spendable inc.	27,600	Spendable income	$25,880	Spendable income	25,700
		Tax saving	$720	Tax saving	$2,540

plans and denying other fringe benefits bear out this conclusion, but in the final analysis they are little more than annoyances. The principal problem with H. R. 10 is that there is allowed as a deduction in computing federal income taxes only 50% of what is contributed for each partner and that the deduction cannot exceed in any year the smaller of 5% of each partner's earned income or $1250. A comparison of the tax savings at various income levels under H. R. 10 and under corporate plans will demonstrate the accuracy of this conclusion. In the examples it is assumed the person involved has no outside income, that he files a joint return with his wife, that 10% of his income will be contributed to the plan except where the $2500 limit applies, and that no state income taxes are payable.

Several conclusions can be drawn from an examination of these figures as follows:

1. If an H. R. 10 plan is adopted, it will have to cover on a non-discriminatory basis non-professional personnel as well as physicians. If 10% of the salaries of physicians is contributed to a H. R. 10 plan, 10% of the salaries of non-professional personnel covered by the plan will also have to be contributed. While the amount contributed for the benefit of non-partners will all be deductible in computing federal income taxes, it will of course decrease by the same amount the sums available for distribution to partners. The reduction in a partner's take home pay resulting from such coverage has not been taken into account in making the calculations set forth above and will, of course, vary from group to group. My guess is that for a group which has a 10% partner and one or more non-professionals for each physician, the contributions for non-partners will equal or exceed the tax savings.

2. If an H. R. 10 plan is adopted, the amounts contributed to it for partners will not be available to them until they retire. Anyone making $25,000 or more a year who wants the maximum of $2500 contributed for his benefit should realize that while his federal income taxes will be cut about $625, his spendable income will be cut about $1825. Unless he is prepared to cut his personal expenses or cut his expenditures for other forms of savings, such as life insurance, he may have trouble adjusting to such a reduction in spendable income.

3. If a medical group incorporates and if it is treated as a corporation for tax purposes, it will have to face both of the problems mentioned in the two preceding paragraphs. However, if such problems can be resolved, the tax savings for a corporate retirement plan will be greater and they will increase as the partner's income increases above $25,000 per year. Moreover, the amounts contributed annually for physicians whose salaries exceed $25,000 will be in excess of $2500 and yet such additional contributions will not result in any appreciable decrease in a physician's spendable income.

PROSPECTS FOR PROFESSIONAL ASSOCIATIONS AND CORPORATIONS

There have been 20 states that have passed statutes in the past two years permitting the formation of professional associations and corporations by physicians and members of other professions and three other states have taken similar action by an Attorney General's opinion or court order. Several hundred groups have organized under these statutes and applied for permission to be taxed as corporations. To the best of my knowledge all of such applications (save one) are still sitting in Washington waiting for a decision by the Treasury.

I think it is clear the Treasury has been sitting on these applications hoping the passage of H. R. 10 would take the pressure off it to approve them. It said as much in 1960 when it submitted its substitute for H. R. 10. Then it said its substitute "would eliminate the problems now resulting from attempts by partnerships to secure classification as a corporation for tax purposes in order to be eligible for coverage in qualified tax plans." This result might have ensued if H. R. 10 had not taken such a restrictive form. But with H. R. 10 passed in a restrictive form, I am sure many professional groups will continue their efforts to be taxed as corporations in order to obtain more favorable tax treatment. I venture to guess that the Treasury will continue to view such efforts with a jaundiced eye and will not readily grant them their wishes at the administrative level. However, I will predict, as I have in the past, that any group which organizes under a professional corporation act (as distinguished

from a professional association act) and takes the Treasury to court on its eligibility to be taxed as a corporation is going to administer a resounding defeat to the Treasury, just as was done in the **Kintner** and **Galt** cases.

Also I believe that we have not heard the end of the Treasury proposals — particularly the one to make corporations with a 70% stockholder subject to all the restrictive provisions of H. R. 10. If tax reform becomes a major piece of Congressional business in 1963, as the President has requested, I feel sure the Treasury will again urge adoption of its proposals which were rejected last month. If its proposals become law so that corporations with 10% stockholders become subject to the restrictive provisions of H. R. 10, then there will no longer be any reasons from a tax point of view to organize as a professional association or corporation, unless your group is large enough so that it has no 10% stockholder or partner.

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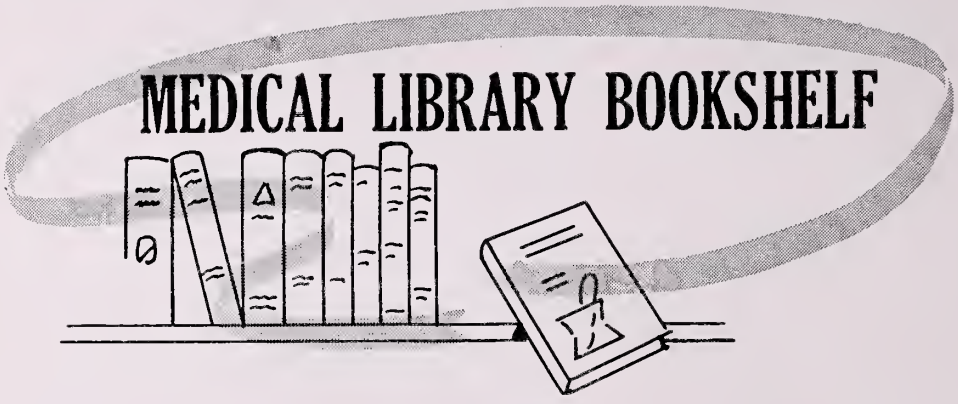
The next oral and clinical examinations (Part II) for all scheduled candidates are being held at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board, April 29 through May 4, 1963.

New and reopened applications, and requests for re-examination in 1964 will be accepted in the office of the Executive Secretary on or before July 1, 1963. Candidates are urged to apply as soon as possible. New applicants, re-opened candidates, and **all re-examinees** are required to submit a duplicate list of hospital dismissals for the preceding twelve months. Requests for re-opening and re-examination will not be accepted without duplicate current dismissal lists.

Current Bulletins outlining present requirements, and application forms may be obtained by writing to the Executive Secretary's office. Applicants are urged to familiarize themselves with the current rules and regulations.

AN INDUSTRY SUPPLIED THE "MUSCLE"

The age we live in is rooted in technology. Machines are everywhere and have been devised to do just about everything. These machines and apparatus, and the **expertise** necessary to manage them, were available when antimicrobial agents appeared. Experts in the processes of fermentation readily converted their methods and apparatus to the production of penicillin; pill-producing machines could be devised for turning out sulfonamides or isoniazid in large quantities; quarters used for the production of antipneumococcic serum from thousands of rabbits served well for animals used to test the efficacy of antibiotics. Behind these elaborate facilities were the resources of the pharmaceutical corporations. The industrial capitalism that arose in the 18th and 19th centuries in Europe and America supplied the "muscle" in the war on infections, the money needed to run the machines and to hire the workers. We cannot say that no other way would have been possible; we can say that this method was tremendously effective. — Harry F. Dowling, M.D., in **Archives of Internal Medicine,** Nov. 1962.



BOOK REVIEWS

Leukemia

The National Cancer Institute is publishing a series of Research Reports on the progress of research towards the scientific solution of the cancer problem.

The first one, Public Health Service Publication No. 960, is Progress against Leukemia by Irwin Auerbach, Supt. of Documents, U. S. Govt. Print. Office, 1962. This summarizes the present knowledge concerning the causes and treatment of leukemia and indicates the direction of current research.

The following are some of the important facts found in this booklet:

In 1955 there were 10,816 deaths from leukemia and it is estimated that in 1962, 13,600 persons will have died from this disease.

Ionizing radiation is one established cause and a few cases have been attributed to the effects of chemicals, principally benzol. There were many incidences of leukemia, acute and granulocytic, among the survivors of atomic bomb explosions in Japan; cases in persons receiving radiotherapy, and children of mothers receiving x-rays during pregnancy.

The National Cancer Institute is conducting a long-term cancer epidemiological survey. One episode was the 8 cases of acute leukemia among school children in the community of Niles, Illinois, a suburb of Chicago. The findings suggested no relationship between leukemia and heredity, radiation, or prior illness, but did suggest to some scientists that viruses might be the cause.

Some evidence to support this concept comes from recent research findings. In 1951 Dr. Ludwig Gross of the V.A. Administration Hospital in New York succeeded in transmitting one form of mouse leukemia with cell-free material after which a number of other viruses capable of inducing various forms of leukemia in rats and mice were isolated. Dr. Charlotte Friend of Memorial Sloan Kettering Cancer Center isolated a virus that stimulates production of antibodies in mice and rabbits. She was able to prepare a vaccine that keeps mice from developing the leukemia-like disease that the virus ordinarily induces. The relationships of the various mouse leukemias agents to one another are at present poorly understood, although electron microscope studies have shown that viruses resemble each other in size and structure.

Dr. John B. Maloney has induced mouse leukemias by an unusual virus in 100 per cent of mice and rats of all strains regardless of age at time of inoculation. An electron microscope study has revealed the presence of virus particles in the blood of animals bearing the Maloney leukemia and a centrifugation scheme has been devised for extracting the virus in essentially pure form which will make possible better study of the biological, biochemical and immunological properties.

Many studies have been made of the morphology and chemistry of normal and malignant leukocytes and most scientists agree that leukemia cells must be qualitatively different from their normal counterparts. However, the only abnormalities found so far have been quantitative.

The best results in treatment have been achieved in children with antimetabolites and steroid hormones. Treatment of acute leukemia patients 2 to 15 years old produces complete remission in 35 per cent and partial in 25 per cent but only 10 to 20 per cent in adults resulting in prolonged survival.

Because there is no way of predicting what patients will respond to treatment, clinicians must evaluate the merits of various dosage schedules, compare results of continuous and intermittent therapy and judge advantages of using drugs individually or in combination.

For acute myelocytic leukemia 6-mercaptopurine has proved useful in management. In chronic leukemia the alkylating agents including the nitrogen mustards, their derivatives and the mustard-like compounds are effective. Two of these compounds, which produce fewer severe side effects, are chlorambucil which has an affinity for lymphocytic tissue, and Myleran, which acts somewhat preferentially on granulocytic tissue.

The most undesirable side effect of all drugs now in use is the damage to bone marrow. Another problem is drug resistance. Some progress has been made in understanding the basis of acquired resistance. Dr. Law, National Cancer Institute, has shown that a transplantable mouse leukemia becomes resistant as a result of random mutation. By mutation some of the leukemic cells become resistant; the drug is merely a selective force, destroying the still-sensitive cells so that the tumor eventually consists of nothing but resistant ones. Little is yet known about the biochemical basis of drug resistance in man.

Some of the other publications on Leukemia that are in our Medical Library are:

Annals of the New York Academy of Sciences. V. 59 art. 5, 1955. Leukocytic Functions by Albert S. Gordon and others.

Ciba Foundation Symposium on Leukemia Research. Little-Brown, 1954.

Disease a Month. Leukemia and Lymphona by J. H. Burchenal and Henry D. Diamond. January 1958. Yearbook.

This includes incidence, etiology, classification, physiology, treatment, therapy and references.

Leukemia by F. Hayhoe. Little-Brown, 1960.

The Leukemias; etiology, pathophysiology and treatment by John W. Rebuck and others. Ed. Academic Press, 1957.

Esther Howard

Medical Librarian

SOUTH DAKOTA SOCIETY OF PATHOLOGISTS SLIDE SEMINAR

The South Dakota Society of Pathologists is sponsoring a Slide Seminar devoted to interesting clinical-pathological problems to be held in conjunction with the South Dakota State Medical Association Convention in Yankton, June 10, 1963. The Seminar, which will be a luncheon meeting, will be conducted by Dr. Richard M. Mulligan, Professor of Pathology, University of Colorado. It will be open to all interested physicians, and a limited number of slide sets and clinical protocols are available at $5.00 a set. Those wishing to participate can obtain these sets and further information concerning the Seminar from Dr. George W. Knabe, Department of Pathology, State University of South Dakota, Vermillion, South Dakota.



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NEWS • NOTES • • • BIRTHS • • • CHANGES • NEWS

Pop's Proverbs

A smile is an excellent armor against despondency.

NEWS NOTES

"Medical Visit to the U.S.S.R." was the topic of Doctor Edmund C. Burke when he spoke to a meeting of the 7th District Medical Society. The meeting was held March 5th at the Westward Ho Country Club.

* * *

Dr. Earl Nelsen, formerly of Cass City, Michigan, is now practicing at Lake Andes, South Dakota.

* * *

The National Registry of Deaths from Mycetism maintains a file of deaths attributed to ingestion of wild mushrooms (1957 to date). Physicians are requested to send notice of all such deaths (age, sex, date, locality) to the undersigned.

Robert W. Buck, M.D.
Secretary
Massachusetts Medical Society
22 The Fenway,
Boston 15, Mass.

The Annual Meeting of the American Academy of Physical Medicine and Rehabilitation will be held on August 26, 1963 at the Sheraton-Dallas Hotel, Dallas, Texas. Address all communications to Doctor Max K. Newman, President, American Academy of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

* * *

Members of the Third District Medical Society met at the New Town Club in Brookings on February 28th. The South Dakota State Department of Health took charge of the evening's program.

QUARTERLY MEETING HELD IN RAPID CITY

Sixty Black Hills District physicians met in Rapid City on February 21st to hear a panel discussion on Diagnosis and Control of Syphilis. Appearing on the Panel were Norm Bredesen, USPHS; Ben Diamond, Director of Laboratories, State Department of Health; Jo Wolf, Lab. Director, Pennington County Health Department; Dr. J. T. Elston, Pathologist; and Dr. Leon Cowan, Dermatologist.

A discussion followed the panel presentation.

The regular quarterly business session was conducted and the meeting closed with a dinner session.

S.D.S.M.A. HAS FOUR AT MENTAL HEALTH SESSIONS

Four persons representing South Dakota attended the AMA's Conference on Mental Health on March 1, 2, at the Drake Hotel in Chicago. Representing the South Dakota State Medical Association were **Dr. Richard Leander,** Chairman of the Association's Committee on Mental Health, and **John C. Foster,** executive secretary of the Association. **Mrs. C. Rodney Stoltz** of Watertown, attended in her capacity as President-Elect of the AMA Auxiliary, and **Miss Florence Dunn** represented the State Health Department. Meetings were concerned primarily with closer cooperation between State agencies and the State Medical Associations.

ASSOCIATION HOLDS LEGISLATIVE SESSION

On March 23, the South Dakota State Medical Association sponsored a meeting in Sioux Falls, on national legislation. Representatives of the AMA presented a one-day briefing for interested physicians in South Dakota to know what the situation is in Washington and what activities are needed to present the physicians' points of view. Approximately 50 people attended the sessions.

KERR-MILLS OPERATION REPORTED IN NORTH DAKOTA

Last fall at the meeting of the North Central Medical Conference, Dr. C. H. Peters of Bismarck, reported on the activities of the Kerr-Mills program in North Dakota from July 1, 1961 to June 30, 1962. Particularly interesting figures brought out by North Dakota are that they received during the year 1,736 applications, of which 1,461 were certified as eligible. However, those transferred from other programs of Welfare totalled 945, or 64.7%. Actually, there were only 516 new cases found in the first year of operation. This is an all-out complete care program which would indicate that the need for medical care for the so-called "near needy" is not as great as many people might have estimated. The North Dakota statistics are borne out by statistics in many other states which lead one to believe that the national program requested by the Administration perhaps has no basis in need whatsoever.

DR. LEEDS GIVEN STATE AWARD

Dr. John F. Leeds, Hot Springs, received the "Physician of the Year" award presented by the State Multiple Handicapped Commission in February. Governor Archie Gubbrud made the award and cited the long service to the profession and particularly to the needs of the handicapped. Dr. Leeds is a Medical Director of the West River Hospital and School for Multiple Handicapped in Hot Springs. Dr. Leeds is a native of Nebraska; received his Bachelor's degree and Doctor's degree from the University of Nebraska; and completed his training in pediatrics. He joined the Butler Clinic in 1952 and has been with that Clinic ever since. He is active in the Lions Club, and holds District and Council offices in the Boy Scouts, as well as holding the job of Fall River County Health Officer.

ROBERT STEWART, M.D. DIES IN MONTANA

Dr. Robert Stewart, a native of Kimball, South Dakota, who practiced briefly at Colton and Highmore, passed away at Broadus, Montana, on February 20, 1963. He is survived by his widow, one daughter, and one son.



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PHARMACEUTICAL SECTION



GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
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Brookings, South Dakota

PHARMACEUTICAL Paper

GOVERNMENT AND INDUSTRY RELATIONSHIPS: THEIR NEW IMPACT ON MEDICINE*

By
John T. Connor**
Rahway, N. J.

My topic this afternoon, as you are well aware, is "Government and Industry Relationships: Their New Impact on Medicine." I am delighted to have the opportunity to explore the subject with you. The emphasis you are placing upon legislative matters at this conference clearly shows your interest in the topic. It certainly is a subject that has concerned me for many years, but particularly since 1959 in the B.K. era — Before Kefauver, that is. In spite of the many emotional aspects, I'll try to conduct a discussion which illuminates but doesn't heat, and which de-emphasizes slogans and catchwords.

Without intending either to criticize or praise the Federal government, I should like to describe Washington's influence — clinically, if you will — in terms of its impact upon industry and medicine. This influence may be direct, as with the new drug legislation. Or it may be indirect, as with the patent policies of the National Institutes of Health. It may be of uncertain effect, as with the proposed financing under Social Security of medical care for older persons. I promise to limit my remarks to matters in which I have had first-hand experience, or — at least — to those in which my company has a strong direct interest.

As a result of many such experiences in recent years, we have come to realize that it's absolutely essential for those of us who will be affected by governmental actions to get right down in the arena and to grapple with the problems. We cannot remain on the sidelines while the battle goes on and then criticize the outcome. We've also come to realize that by playing a constructive as well as an active role, the results that do emerge can be of benefit to the participants, as well as being in the national interest.

Cuban Prisoner Exchange

A good example of constructive cooperation of the pharmaceutical industry with our Federal government is the recent release of the Cuban prisoners. This was in exchange for many services and commodities given willingly by many different industries in this country, but primarily for drugs and medicines donated by the U. S. pharmaceutical industry. It is my deep conviction — and I had the privilege of participating in the handling of the project almost from its beginning — that the entire concept was a "ten

*An address presented at the 1963 Conference for Physicians sponsored by the Texas Medical Association, Austin, Texas, January 19, 1963.
**President, Merck & Co., Inc.

strike," brilliantly conceived and executed with incredible success.

I can assure you that leading companies in the industry responded immediately and affirmatively when our top government officials in Washington defined the national security and public interests in attaining the release of those prisoners. The proposal of the government spokesmen, made directly to officials of the Pharmaceutical Manufacturers Association, would enable companies to participate with little or no financial loss to themselves or their stockholders. Some companies, of course, had doubts and questions, particularly on moral grounds because of the ransom implications. But no pressure whatsoever was applied to them by the government officials involved. And in due course, nearly all of the doubters resolved their questions in favor of participating.

The results are still hard to believe. In about ten days, the first shipment of about $10 million worth of drugs and medicines, and significant amounts of foods and medical supplies and instruments, were pledged, packed and assembled at various points all over the country. These were shipped by air, rail and trucks to Florida, where the African Pilot and various airplanes were loaded and sent to Havana. This made possible the release of the prisoners and the joyful family reunions for Christmas that we all saw on T.V. To me, this was a dramatic example of what free men can do in cooperation with the officials of their own government to bring about results beneficial to the public interest and the interests of the participants. Certainly the men released from Castro's prisons — and their families — benefit from this action. And I think all of us as citizens of the United States share our President's feeling of relief that these men are now safe again.

Contributing companies lost little or none of their stockholders' money through participation. This was the beneficial result of the government's prompt handling of the individual tax problems — all, of course, in accordance with existing laws and regulations.

It is even possible that the pharmaceutical industry may have benefited in the public relations area as a result. The people of the United States and our governmental officials have a better understanding of how valuable a national asset is our pharmaceutical industry — a point well understood in time of war or national emergency, but apt to be forgotten in between.

The Federal government itself gave dramatic evidence of its interest through tax rulings which made the whole transaction possible. Without the tax rulings, absolutely nothing would have happened. The men still would be in prison.

The Drug Amendments of 1962

Totally different in character — but another aspect of government-industry relations — was the pharmaceutical industry's participation in the legislative activities that led to the enactment of the Kefauver-Harris Drug Amendments Act of 1962. Drug company participation consisted largely of testifying at the hearings and of supplying unbelievable quantities of information. It was a fascinating — if not an enviable — experience.

The stated purpose of Senator Kefauver's investigation of the industry, starting in 1959, was to find out to what extent the drug industry practiced so-called "administered pricing." The term is vague . . . a source of confusion even among economists. Furthermore, it readily became apparent that Senator Kefauver and his staff members were firing their salvos to cover a beachhead operation of quite a different nature.

Soon, they were directing simultaneous attacks against pharmaceutical industry concentration, competition, patents and the validity of industrial research. The attack then wandered into promotion and the cost of promotion and on into the matter of Food and Drug Administration performance.

But aside from the querulousness over the government's lack of prior-approval power over new-drug efficacy, it did not get into the area of drug safety — particularly the matter of drug-safety during the clinical investigation stage. Industry, for its part, made the best defense it could against the massive attack — and it quietly proposed reforms in the food-and-drug law field.

Against this backdrop, the thalidomide issue took the stage. In July, when thalidomide became top news across the nation,

the public became aware for the first time of the widespread human tragedy abroad that seemingly stemmed from the use of this drug. Federal agencies launched a nationwide roundup of the supplies then out for clinical investigation here. And the problems of individual expectant mothers became the source of public debates.

The thalidomide episode had an immediate consequence for the Kefauver legislative effort. It was turned almost completely into a vehicle for strengthening the Food and Drug Law controls over the industry, particularly as to clinical investigation and the new-drug approval process.

In the immediate wake of the thalidomide publicity, the drug law amendments of 1962 were passed and signed into law. Although the law bears Senator Kefauver's name, it is a far cry from the measure that he introduced in the spring of 1961. Gone — fortunately — are most of the so-called antitrust features as well as the provisions attacking the U. S. patent system. What remains, primarily, are food and drug amendments. Many grew out of proposals that had been either advanced or advocated by the drug industry itself. Yet — in the public mind, and too often in the public press — industry has been characterized erroneously as having completely opposed the bill.

What will the new drug bill do? Some of the requirements that must be met are these:

Every company must meet minimum standards of good practice in its manufacturing and control operations. Each company must register with the F.D.A., and the agency must inspect each registered manufacturer at least once every two years. The inspectors have the authority to look at everything bearing upon enforcement of the act. But they may not require manufacturers to produce financial, sales, personnel and research data which has no relationship to other provisions of the law.

Prior to marketing — when the new drug is still in the test stage — clinicians must inform patients that they are participating in a test and obtain the patient's consent. Exception is made if the clinician feels such a procedure is not feasible, or if he believes that telling patients is not in the patients' best interest.

The initial period for F.D.A. consideration of a New Drug Application is extended from 60 to 180 days. In such applications, companies are required to furnish substantial evidence that a drug can be removed from the market without a prior hearing, if it is believed to represent an imminent hazard to the public health.

The F.D.A. can select generic names, when it deems this necessary. And the generic name of a compound must be included on labels and in advertising in type at least half as large as that of the trade name. Ads for prescription drugs must include a brief summary of the product's side effects, contraindications and effectiveness.

On the face of it, the new law — on the whole — is sound. Competently administered, it will allow the industry's leaders to continue to develop new and better products through research. These companies will continue to be able to manufacture and distribute high quality products and to maintain — perhaps even to improve — their competitive position. Undoubtedly, however, the law will result in increased expenses and also in delays in the introduction of new products.

What will the new law mean to medical practice? The stronger provisions for enforcement of manufacturing standards — if effectively applied throughout the industry — may give the physician greater assurance of quality products. The registration of manufacturers should permit more effective enforcement of the law as to all drug producers. The summary of toxicity and side-effects data in all advertisements may help the physician to the extent that he may consider an ad an appropriate vehicle for this type of information.

Food And Drug Administration

The provision requiring the government's prior approval of a compound's efficacy raises questions. In actual practice, the F.D.A. has been relating effectiveness to safety for many years. Now that the law spells this out, will there be any change in actual F.D.A. practice?

Another serious question centers around the time limits for consideration of New Drug Applications by the F.D.A. Until now, the F.D.A. has had a period of 60 days to act upon an application. And this could be doubled if

the F.D.A. wished. In theory, the new product could then be marketed — if the F.D.A. had not rejected the application, or otherwise declared it inadequate or incomplete. In practice, of course, the agency had at its disposal about all the techniques it needed to acquire additional time for its decisions.

The new law gives the F.D.A. 180 days — six months — for the initial consideration of an application. For all practical purposes, the agency still has the power to take about all the time it wants. The question must be raised, however, whether the F.D.A. has the facilities — and the manpower — to process applications within a reasonable period. Public interest requires this, and so does the industry's interest.

Last summer, at the height of the thalidomide furor, President Kennedy announced a 25% increase in the F.D.A. staff — the largest single increase in its history. Less publicized, a few months later, came Congressional action eliminating the necessary supplemental appropriation. Only fourteen physicians now staff the F.D.A.'s New Drug Branch — the department responsible for processing hundreds of applications each year. Currently, one hundred New Drug Applications are pending, according to information received by the Pharmaceutical Manufacturers Association.

The Acting Medical Director of the F.D.A., Dr. Ralph Smith, estimated recently that some two to three thousand drugs are under clinical study in this country. Many of them will be submitted formally under a New Drug Application. How can an understaffed, overworked and underpaid F.D.A. be expected to cope with this onslaught of data, much of it requiring the most sensitive judgment?

Nor is this the full extent of the F.D.A.'s manpower problem. Regulations just issued charge the F.D.A. with keeping watch on clinical tests. Not directly, however. Sponsors of a test must get the required data from the individual investigators and keep the F.D.A. fully informed. The Federal agency then has authority — if it sees fit — to question data or procedures, and even to put a stop to the clinical test if there is evidence the compound is unsafe or ineffective. These added responsibilities — inevitably — will place a still greater strain on the F.D.A.'s already overtaxed scientific and medical manpower.

It was my privilege to serve on the Citizens Advisory Committee which studied the function and needs of the F.D.A. in considerable detail this last summer. The committee recommended ten basic steps which it believed would improve the agency. It asked for improved medical and scientific orientation and leadership; basic organizational changes and an upgrading of personnel. The latter is urgently needed. The committee also made a special plea to the executive branch of government and to Congress to provide the F.D.A. with the funds necessary to make these improvements.

At a time when the Administration is thinking of a tax cut and economies on a national scale are clearly indicated, it may appear unreasonable to advocate major increases in the budget of a regulatory agency. But an agency is useless if it becomes so hopelessly overworked that it cannot function. Unless the F.D.A. budget is increased — and especially unless medical and scientific staff and facilities are expanded and improved — the mechanism for drug regulation in this nation is in real danger of collapse. The new Congress has an opportunity and an obligation to provide these funds. It would be a senseless tragedy if this nation forfeited its leadership in drug progress, not for lack of discoveries, but because a regulatory agency could not keep pace.

The National Institutes of Health

Curiously, while the F.D.A. remains an orphan, another Federal health establishment is the apple of the Congressional eye: The National Institutes of Health. An article in a recent issue of the Journal, "Science," said of the 20-year growth of the Institutes: "Every year, with uncommon enthusiasm, Congress approves larger and larger expenditures for the study of human disease. Already N.I.H. has become the hub of an enormous research effort, and its program probably will continue to expand . . . It was during the 1930's that N.I.H. began laying the groundwork for its current research program. Before the end of World War II, Federal pub-

lic health officials had formulated the objectives, worked out the basic organizational pattern, and gained the legislative authority for a great postwar medical research effort. Their far-sighted policy, carefully calculated to advance the cause of Federally sponsored medical research, made it possible for the N.I.H. to become the giant that it is today."

As you know, gentlemen, the N.I.H. has become a billion-dollar-a-year enterprise. Much of its research has been excellent. Its influence upon our medical schools and research hospitals is profound. And it is moving more and more into drug and clinical research. As it does, new questions arise about relationships with the medical profession and the pharmaceutical industry, as well as with the F.D.A. All of us will be grappling with these questions for some years to come. Certainly, we in industry are seriously concerned about the N.I.H. patent policies and practices which we think are misguided. We think that — in the long run — they will prove contrary to the public interest because they will rob all pharmaceutical firms participating in the N.I.H. program of the necessary incentives to develop, produce and market the products which might emerge.

Medical Education

Have you noticed that — while I have been talking about events of today — my concern has been with the future? The new drug laws that will affect the manufacture of tomorrow's prescription medicines. The regulations that will guide future clinical research. The writing-on-the-wall in a new Federal patent policy. In each instance, a chain of events started by a new act or a new policy in Washington. But it is equally possible for the current to flow in the opposite direction. The initiative of industry and of medicine can affect the actions — and even the policies — of government. Education, and particularly medical education, furnishes a prime example.

The economic obstacles to obtaining a modern medical education are huge. Yet doctors must be trained in ever increasing numbers to meet the needs of an expanding population. It is often suggested that the Federal government should step in. But if Washington picks up the tab, Washington will supervise.

The alternative to Federal intervention, of course, is for the existing system to work more effectively to meet the new needs and conditions that have developed. If the job is well done by private means, Washington will be deprived of its opening wedge. For many reasons, I would like to see private initiative keep control. This is why the new Student Loan Program which the A.M.A. is sponsoring strikes me as being such an important and hopeful undertaking.

I understand that it was reported recently in Los Angeles that now more than one out of every ten medical students in the nation is participating in this private, self-relying program. Some $9 million in loans are now helping tomorrow's physicians receive their education. And this does not include the 1,800 interns and residents who also joined the program in its first nine months.

But the need is considerably greater. Today there is a guarantee fund of $900,000, which multiplied by the factor of twelve and one-half when processed through the banks of the nation makes about $11 million available. But that guarantee fund should be at least $2 million to do the job that's necessary.

Organized medicine is to be congratulated for establishing such a program. The contributions of individual physicians and their societies have been gratifying. Industry also has pitched in. I am proud that Merck Sharp & Dohme has been a leader in this important activity.

Medical Care for the Aged

It may be that private initiative and hustle can shut the door to other unwanted Federal involvement. In this regard, financing needed medical care for the elderly presents a gigantic challenge. We are all aware — and by "all" I include the members of Congress — that the issue is one of great urgency.

In recent years — and especially in recent months — there have been a number of encouraging developments in the voluntary insurance field. We have seen expansion of Blue Shield and Blue Cross plans. Also noteworthy has been the formation of statewide associations, such as those of Connecticut and New York, in which many insurance companies pool resources to provide non-profit

health coverage for older persons. Yet many persons will continue to find the cost of adequate insurance policies prohibitive.

I recognize that the needs of these people for adequate coverage must be met in an era when hospital and medical bills are rising rapidly because of the more effective facilities and procedures now available. But I tend to share the misgivings of many doctors who believe it would be dangerous to give Washington the responsibility to control medical payments for any segment of the population. Before long, the bureaucratic controls would be extended and extended and extended.

I would like to suggest that there is one avenue towards helping to meet the medical expenses of the elderly which we have barely begun to explore. I refer to industry's potential for taking care of the medical needs of its own retired employees. I know from the experience of my own company that such plans are immensely popular with our former employees who are now retired. Since 1958, Merck has maintained — at its own expense — hospital and surgical-cost insurance for its retired men and women.

Industry-sponsored insurance is by no means the final answer to the national problem of helping the aged to meet medical payments. But we must remember that industry provides the living income for the great percentage of America's families. As a consequence, widespread participation by industry in the health affairs of its own retired employees — very probably — would change substantially the scope of the problem which concerns us all. And the remaining part might be more manageable.

We must also grapple with the problem of easing the burden of drug costs for persons other than the elderly when the need is great and resources few. Prescription insurance may offer a challenging opportunity to handle part of the problem. It has been tried in several areas. Most recently, the Group Health Association in Washington, D. C. revealed that it had been experimenting with prepaid drug benefits for the past two and one-half years. And it will continue to offer such coverage to its policy holders. Another recent move of possible promise is the discussion under way between the American Pharmaceutical Association and the Blue Cross to consider an approach to prescription insurance. So here again, although the undertaking is full of difficulties, a private means may evolve to meet a public need.

It often happens that Washington pushes into areas where we find its presence uncomfortable simply because private initiative has failed to do the job. Those of us who look upon self-reliance as a cardinal virtue had better look to our own performance before we criticize government intervention too loudly.

In a world growing constantly more complex, it is inevitable that government and industry must develop increasingly close relationships. And this — as we have seen — will have its effect upon medicine. But if we keep our business and professional houses in order, we can make our most effective contribution towards preserving our nation as we like and prefer it. Doing our job right at home is the best way of keeping Washington at its proper distance.

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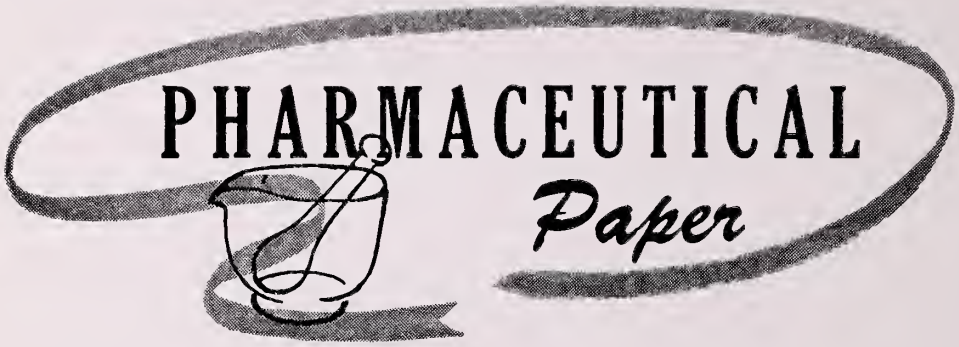
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WISCONSIN BLUE CROSS PILOT DRUG PREPAYMENT PROGRAM FOR EMPLOYEES

The Board of Directors of Associated Hospital Service Inc. (the Wisconsin Blue Cross Plan) has authorized an allocation of funds to finance a one-year experimental program to prepay the costs of pharmaceutical services for Blue Cross employees. The following is a brief description of the program.

Time

The program went into effect February 1, 1963 and will terminate January 31, 1964.

Whom Will It Cover?

The program is limited to full-time Blue Cross employees and their dependents. Participation by employees is voluntary. The costs will be borne entirely by Blue Cross. Approximately 345 employees and their dependents are eligible to participate.

What Services Are Provided?

Coverage under this program includes the following:

1. Any medication for which the law requires a prescription and manufactured prescriptions (those prepared by the pharmacist utilizing two or more ingredients), prescribed for human consumption or use, in quantities as directed by the prescription.

2. Insulin, injectable 10cc., with a deductible of $1.00. Certification of need, dosage and insulin type from the attending physician will be secured by Blue Cross. Participants covered under the program requesting insulin, will present a special Group 21 insulin identification card along with their regular Group 21 identification card.

The above services, however, are available with the following limitations:

1. No renewals will be authorized. A new written or oral prescription must be obtained for each order.

2. No prescription written more than two weeks prior to date of presentation to the pharmacist will be honored under the program.

3. The prescribed quantity of medication will not exceed a 34-day supply.

How The Program Works

1. Participating Pharmacists

Employees are free to choose any pharmacist they wish provided he is a Participating Pharmacist as defined by this program.

Participating Pharmacists are those licensed in the State of Wisconsin who have agreed to abide by the "Principles of Professional Pharmaceutical Practice," a nationally recognized guide for the pharmaceutical profession.

2. Subscriber Identification

When there is a need for pharmaceutical service, Blue Cross employees will present their regular Blue Cross Identification Card, which bears Group No. 21, and inform the

Participating Pharmacist of their Blue Cross employment. Those needing insulin will present a special Identification Card.

3. Payments to Pharmacists

Pharmacists will be paid the acquisition cost of any medication for which the law requires a prescription, or manufactured prescriptions (those prepared by the pharmacist utilizing two or more ingredients) for human consumption or use, in quantities as directed by the prescription. For purposes of the pilot study, the latest issue of the "Red Book" and "Blue Book," authoritative guides for the industry, will be used as a basis to determine the acquisition cost.

In addition, pharmacists will be reimbursed $1.90 for professional services, except for insulin. Pharmacists will be reimbursed their normal retail price less $1.00 for insulin.

Participating Pharmacists will be provided with the necessary claim forms and envelopes for billing purposes. Claim forms will be sent to Blue Cross on a monthly basis. Blue Cross will make payment within 30 days after receiving claim forms.

4. Two Organizations Cooperate in This Program

This program is the result of cooperative study, meetings and planning by the Wisconsin Pharmaceutical Association and Blue Cross.

5. What are the Purposes of the Prepaid Pharmaceutical Program?

The Wisconsin Pharmaceutical Association and Blue Cross are interested in this experimental program for the following major reasons:

a. It is hoped that the experience will demonstrate the feasibility of offering prepaid pharmaceutical coverage to groups on an underwritten basis.
b. It is hoped that the experience will show that professional pharmaceutical services can be administered on a sound, practical basis under a Major Medical Contract.

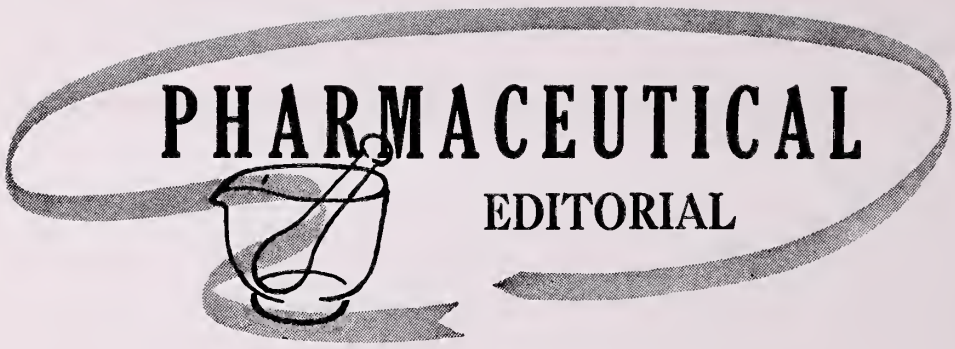
Since drugs play such a prominent part in health care and account for a considerable portion of the total health care bill, both organizations believe that the interests of the public would be better served if pharmaceutical services could be provided on a prepaid basis. Unfortunately, there is very little actual data or experience as yet to indicate whether these goals, however desirable they may be, are feasible on a basis which is sound, economical and equitable to all concerned.

This is the reason for this pilot program. There is no way of knowing now whether the hopes will be realized. After the program is concluded it will be carefully evaluated by both organizations to determine whether any further steps can or should be taken.

NEW DRUG ADVERTISEMENTS

Will this (new drug) law and the regulations hurt journal advertising? It is difficult at this point for me to give a categorical answer to this question. Certainly, we are not going to stop advertising. The requirement that we give a brief summary relating to side effects, contraindications and effectiveness will not deter manufacturers from advertising provided the regulations are reasonable. However, there is one respect in which I am afraid all advertising will be affected. Our largest advertising budgets are devoted to the promotion of new products. In my opinion, present administrative procedures and the requirements of the new law will indisputably slow down the development and marketing of new drugs, which means that each year we will have fewer new drugs to advertise. However, as an offset against this, having invested more in the development of a new drug, we will be willing also to invest more in its promotion because we can't take a chance of faltering in this final payoff step. And, it is entirely possible that the net effect on journal advertising will be unchanged in the long run. — Theodore G. Klumpp, M.D., President, Winthrop Laboratories, in **Rocky Mountain Medical Journal,** Dec. 1962.

OPPORTUNITY for Pharmacist in community with $350,000 new hospital now in operation, a medical doctor and a dental doctor. For further information write Bowdle Jaycees, c/o Floyd Miller, Bowdle. S. D.



THE MAGIC GARDEN

(Robins Reader)

William Wordsworth once wrote, "There is not a man that lives who hath not known his god-like hours." Many centuries earlier, Ovid, the poet-philosopher, described such periods of inspiration as, "a holy rapture that springs from the seeds of the Divine Mind, sown in Man." Note that he did not say "sown in some men." He said, "sown in Man" — and that takes in all of us!

At pinnacle moments each of us has felt this "holy rapture." It is experienced not just by poets and artists, but by lawyers, doctors, housewives, teachers, businessmen, inventors, ministers, people in every walk of life. In most of us it is such a transient experience that not much comes of it. To grow and thrive in us these "seeds of the divine mind" must be carefully murtured. We must recognize these flashes of genius for what they are — the source of our wisdom.

Our utilization of these resources carries with it two obligations: We must recognize that the people around us, even though they may not know it, have the same resources latent within them; and, we must do what we can to help them to become aware of them — and use them. We can do this best, not by "preaching" to them, but by encouraging them, by stimulating their self-confidence, by giving them pats on the back when they have earned them.

The results can be surprising — —not only for them but for ourselves. In our efforts to help their seeds to flower, we water our own as well.

MOLECULAR MODIFICATIONS

Much has been written and said in recent months about the need to curtail the distribution of drug products that are "molecular modifications" of previously marketed compounds. It is proposed that molecular modifications be made available only if they are found to have significantly greater therapeutic effect. This term, "greater therapeutic effect," is indeed vague and is only one criterion which should be met. Among the other criteria that must be fulfilled are lesser toxicity, lower dosage levels, improved dosage forms, lower costs, greater stability, sustained potency over longer periods of time, and other recognized indications of useful advances in drug therapy.

In view of the history of pharmaceutical research and the advances made in medical technology, molecular modifications should not be thwarted; rather, they should be encouraged. Experience has demonstrated beyond doubt that new compounds chemically similar to existing ones may prove to be medically superior. If restrictions of this type had been enforced throughout the history of pharmacy and medicine, penicillin G might have remained the world's only antibiotic. None of the tremendous improvements in antibiotic therapy would now be available. Likewise, the first sulfonamide, toxic sulfanilamide, might long have continued to be the only sulfa compound at the physician's command.

History is full of examples of lifesaving drugs which represent only slight molecular

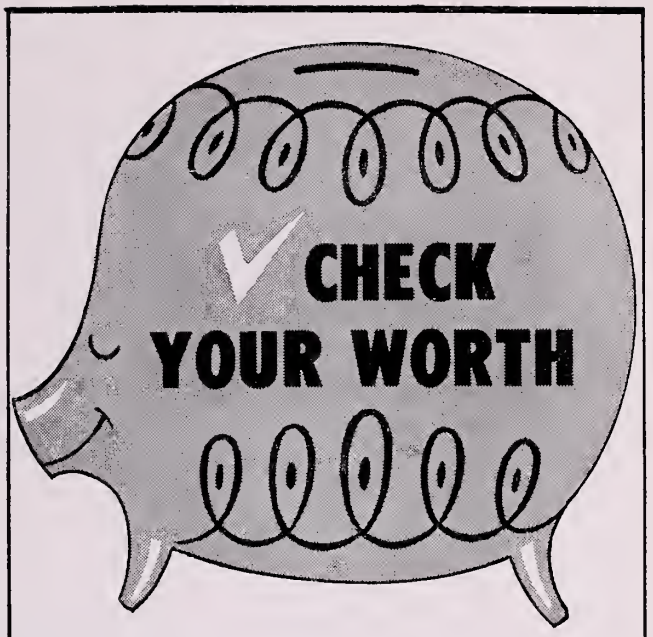
changes from ineffective substances. Dr. Philip S. Hench, winner of the Nobel Prize and expert on rheumatoid arthritis, testifying before the Senate Subcommittee on Antitrust and Monopoly last year, said that the difference between Kendall's Compound A, a medically useless substance, and Kendall's Compound E, now known as cortisone, was only a matter of molecular manipulation.

If proposals are adopted to restrict the marketing of new drugs just because there is only a slight difference, it is possible that the welfare of the American people would not be served. It is entirely conceivable that the first crude drug constituting a breakthrough in any new field of therapy could remain the only medicine available. Safer, more effective drugs would remain on the shelf of the manufacturer, and our nation's people would not be served in the best way possible.

The system under which a miracle of progress has been achieved in the medical fields has great merits. Indeed, all tampering with it should be undertaken with caution, but unquestionably any system can be improved. New conditions may make necessary new methods, but let's not take a momentarily popular course at the expense of the long-term public interest.

DRUG MANUFACTURING — A PUBLIC UTILITY?

I sometimes suspect that our most persistent and vocal critics are not so much interested in correcting our alleged abuses within the context of American medicine, as in undermining the very structure of American medicine itself. As one man frankly suggested to a Congressional subcommittee: "Drugs should be treated like a public utility." — T. F. Davies Haines, President, Ciba Pharmaceutical Company, in **J. of Indiana State Med. Assn.,** Dec. 1962.



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You're in for a big surprise. Include every room — and don't forget the clothes closets, bureau drawers, jewelry, furs and treasured antiques. Be sure and include the garden, yard, and garage. Now total the value at today's replacement costs. Surprised?

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PRESIDENT'S PAGE

Rx



I have been warned that this will be published in the April issue, so a belated April Fool to you, as I am writing this on the 28th of February.

Under present conditions many of our old maxims should be revised to fit in with "The New Frontier." For example: "Early to bed and early to rise, A non-union worker, I surmise." Or: "Life, liberty, and a part of the taxes."

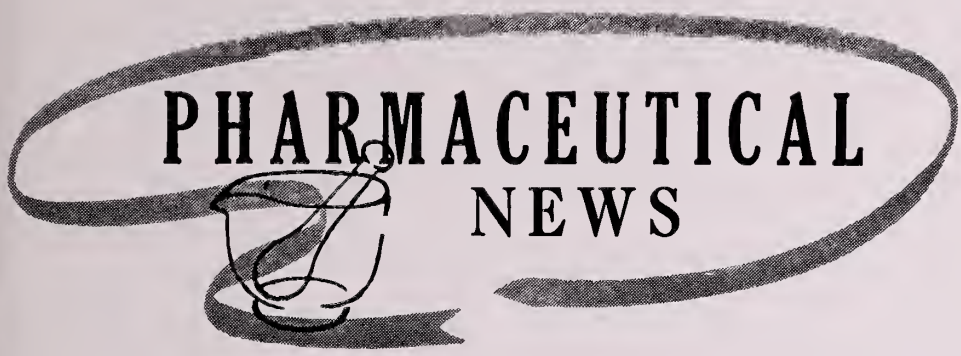
Something new has been added to the Wall Drug Store and, like the "Cowboy Band," it can be seen for free. I refer to the pharmacist-legislator. Until the recent appointment of Bill Hustead, a pharmacist-legislator in South Dakota was considered as extinct as the Dodo bird. Now we have a real live one, and located only 1,529 miles from Los Angeles, California.

Reservations are being made at the Holiday Inn, Pierre, South Dakota, for our state convention starting June 23. Get your reservation in early as 100 per cent attendance is expected.

Sincerely,

L. B. Urton

President



NEWS IN BRIEF FROM AROUND THE STATE

Mr. and Mrs. John Nelson, Arlington, and **Mr. and Mrs. Bob Volk,** Groton, took a four-day tour of Lederle Laboratories in March.

George Paul, formerly of Selby, is the new pharmacist-manager of the Sioux Falls Clinic Pharmacy.

Keith Anderson of Kreiser's Pharmacy, Sioux Falls, spent three weeks last winter touring Switzerland and getting in some skiing. **Henry Kruse** and **Ray Simpson** served as relief pharmacists.

Cliff Van Hove is the new pharmacist-manager of Mills-Park Prescription Shop, Sioux Falls.

John Roos of Jones Drug, Redfield, spent a month in Arizona and New Mexico. His interest was in watching spring baseball training.

T. C. Rutherford and sons have purchased a 50-foot frontage on Main Street in Winner which will be the site of an all-new, super drug store.

Don Strahl, pharmacist for Locke Pharmacy, Gregory, is now in the army.

Mr. and Mrs. Joe Statz, Parkston, took **Mrs. Joe Statz, Sr.** to Omaha from where Mrs. Statz, Sr., went on to Phoenix, Arizona, for a month of winter vacationing.

Fifty pharmacists from various parts of the State attended the legislative hearing on Senate Bill 26 which concerned the sale of veterinary medicines. The hearing was held in Pierre, January 31st.

Mr. and Mrs. Luther Breen, Scotland, spent a month winter vacationing in Honolulu and San Diego. They visited with their daughter on the trip.

Mr. and Mrs. Ernest Greening, Dell Rapids, spent several weeks in Brownsville, Texas, last winter.

Locke Pharmacy, Gregory, has installed new fixtures.

Vernon G. Olson, formerly with H. H. Humphrey & Sons, Inc., Huron, is the new pharmacist with Harms Pharmacy, Watertown, Minnesota.

EIGHT RECEIVE CERTIFICATES AS REGISTERED PHARMACISTS

The State Board of Pharmacy has issued certificates of registration to eight recent college graduates following examinations given in January, 1963.

The newly registered pharmacists are **Gary Bell (3470),** Wessington Springs; **Sharon L. Berkner (3471),** Milbank; **Kenneth W. Bray (3472),** Aberdeen; **Judy Cullen (3473),** Chamberlain; **B. Judith Hladik (3474),** Rapid City; **Mrs. Sharon L. Krebs (3475),** Wakonda; **Jon C. Lee (3476),** Clarkfield, Minnesota; and **Mrs. Barbara Underhill (3477),** Aberdeen.

STATE COLLEGE STAFF MEMBER RECEIVES PROMOTION

Dr. Gary W. Omodt, assistant professor of pharmaceutical chemistry, South Dakota State College, has been selected for promotion to the rank of associate professor, according to a recent announcement by President H. M. Briggs. The promotion will become effective July 1.

Dr. Omodt received his initial appointment to the staff in 1958 as an assistant professor. A graduate in pharmacy of the University of Minnesota, he also received his doctorate from that institution.

PHARMACY ORGANIZATIONS CONDUCT BROOKINGS HEART DRIVE

The Heart Sunday door-to-door canvass conducted in Brookings, February 24, was declared a success by Kenneth Redman, local chairman. Nearly $1,100 was collected, all of which will be used for the fight against heart disease, since all services and expenses were donated by the local committee.

The canvass was organized and conducted by Kappa Psi Fraternity. Wallace Fairfield, Fraternity Regent, was vice chairman of the drive. Members of Kappa Epsilon Fraternity for Women and of the Student Branch of the American Pharmaceutical Association assisted.

Chairman Redman thanks the Brookings Register, Radio Station KBRK and the College Theater managers for donating publicity for the drive. Appreciation is also expressed to the several business establishments for helping with coin collections and to the community for its generous support.

CLARK WOMAN IS WINNER OF HAWAIIAN TRIP

Mrs. Adolph Gammelin, Clark, was the recent winner in an Hawaiian Trip Contest sponsored by Northwestern Drug Company. She and her husband joined the Johnny Morris Hawaiian Tour Group at Minneapolis for a sixteen-day tour of the Islands, returning to Clark on February 13th.

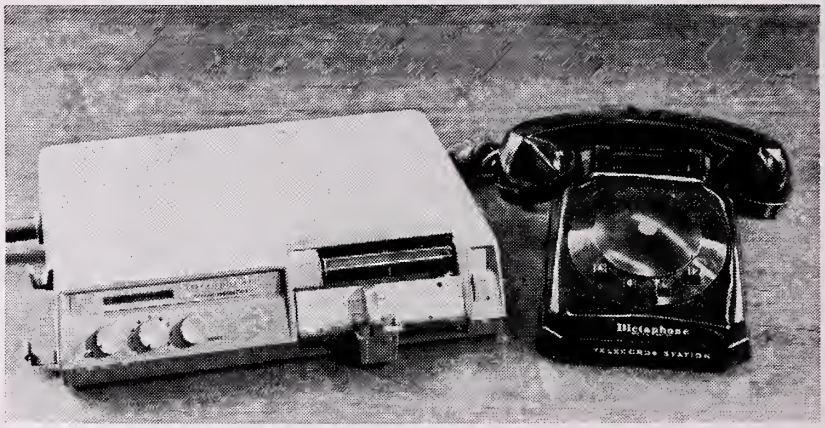
Al Knutson, owner of Knutson Drug, Clark, presented Mrs. Gammelin with a check for $100, expense money, which she won in addition to tour tickets for two. Al took added pleasure in making the presentation since this is the same trip that he and **Mrs. Knutson** took last year.

CHARM

"It's a sort of a bloom on a woman. If you have it you don't need to have anything else; and if you don't have it, it doesn't much matter what else you have."

Sir James M. Barrie

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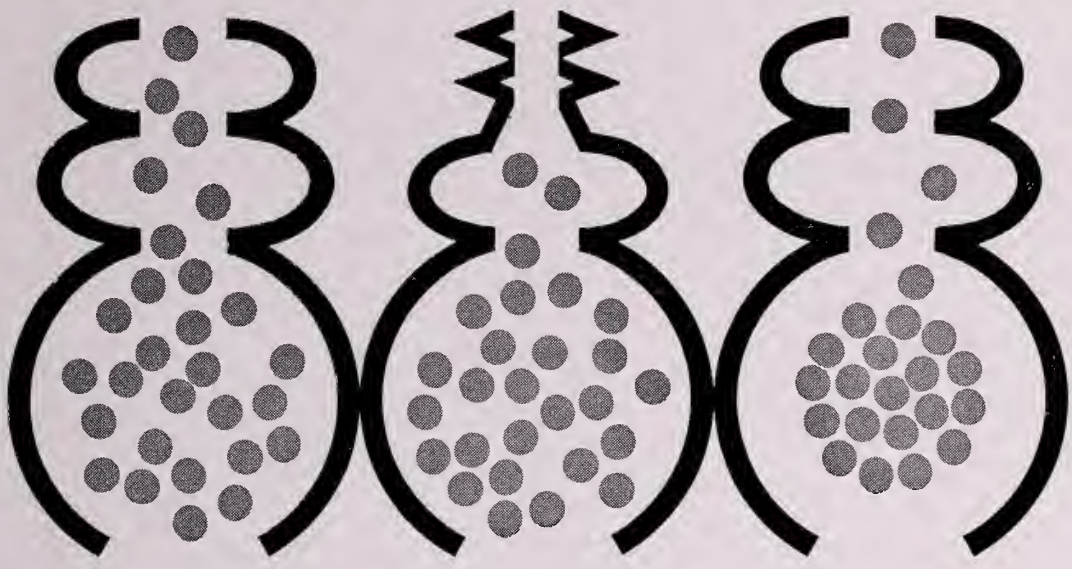


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lowers motility | relieves cramping | stops diarrhea

LOMOTIL® Antidiarrheal tablets and liquid

(brand of diphenoxylate hydrochloride with atropine sulfate)

Traditionally the most effective means of slowing excess intestinal motility in diarrhea and so of relieving the disorder have been the opium derivatives. Now Lomotil makes available an antidiarrheal agent[1] of greater therapeutic efficiency than morphine.

By controlling hypermotility, the basic mechanical dysfunction of diarrhea, Lomotil reduces the frequency and fluidity of stools, diminishes cramping and controls diarrhea in many patients in whom other drugs have proved inadequate.

In a recent clinical report Cayer and Sohmer[2] state: "The alleviation of symptoms [with Lomotil] was usually prompt, occurring within 24 to 72 hours even in the long-standing chronic cases. . . . A surprisingly satisfactory response was obtained in 75 per cent of the patients with regional enteritis and in 63 per cent of those with ulcerative colitis, all of whom had failed to respond to other measures."

The high therapeutic efficiency of Lomotil, its safety, convenience and economy may be used to advantage in acute or chronic diarrhea.

Dosage: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

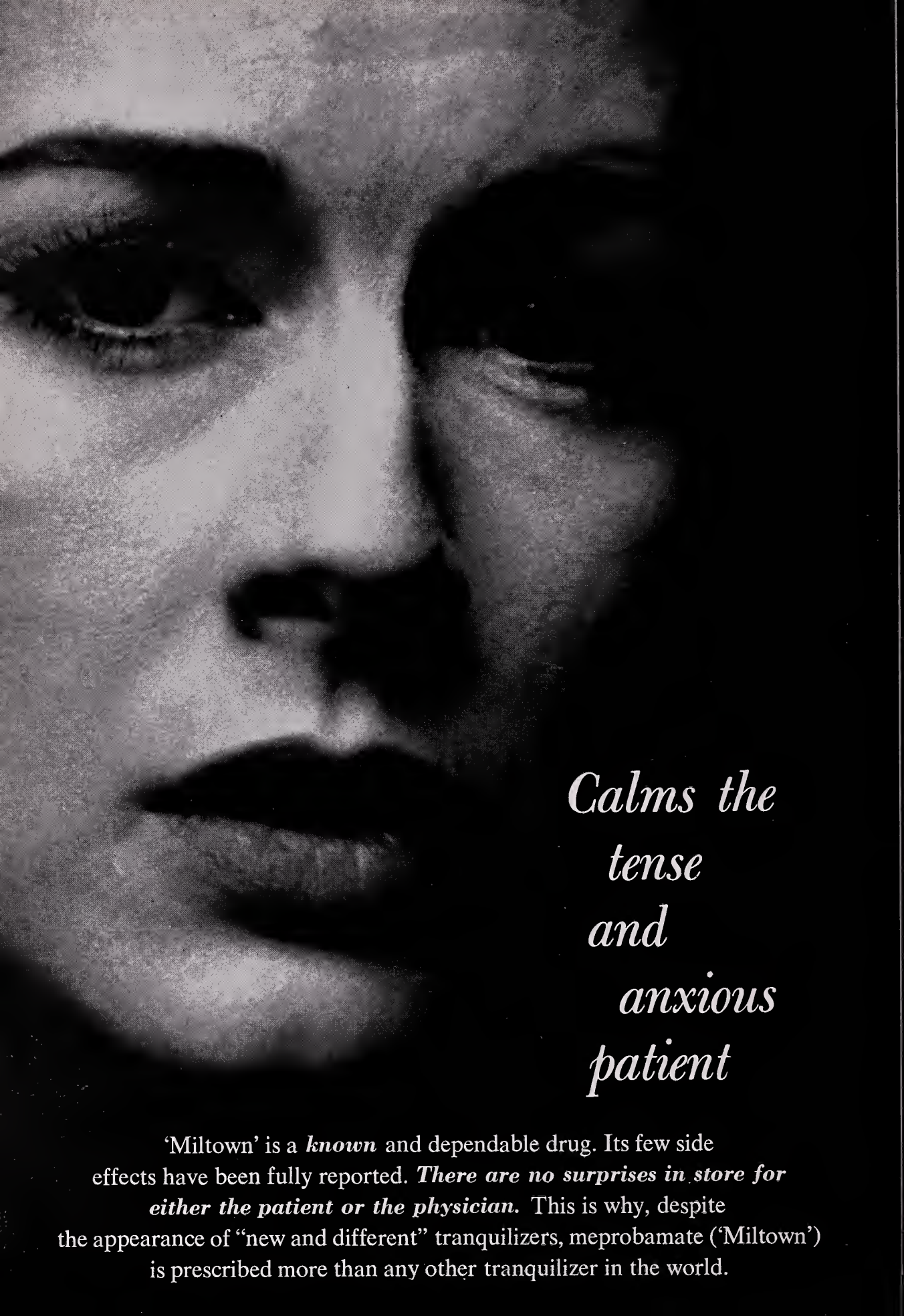
Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. I. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.

2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22:600-604 (Dec.) 1961.

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'Miltown' is a ***known*** and dependable drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.*** This is why, despite the appearance of "new and different" tranquilizers, meprobamate ('Miltown') is prescribed more than any other tranquilizer in the world.

Clinically Proven

in more than 750 published clinical studies
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Outstanding Record of Effectiveness and Safety

1. Relieves anxiety and anxious depression in a broad spectrum of clinical conditions. Doesn't leave patients "too groggy" to work or think or learn.

2. Relaxes both mind and skeletal muscle. Relieves physical tension as well as emotional stress.

3. Toxicity is low and side effects are few. Does not cause liver damage or Parkinson-like effects.

USUAL DOSAGE: One or two 400 mg. tablets t.i.d.
SUPPLIED: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as **Meprotabs®** – 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as **Meprospan®-400** and **Meprospan®-200** (containing respectively 400 mg. and 200 mg. meprobamate).

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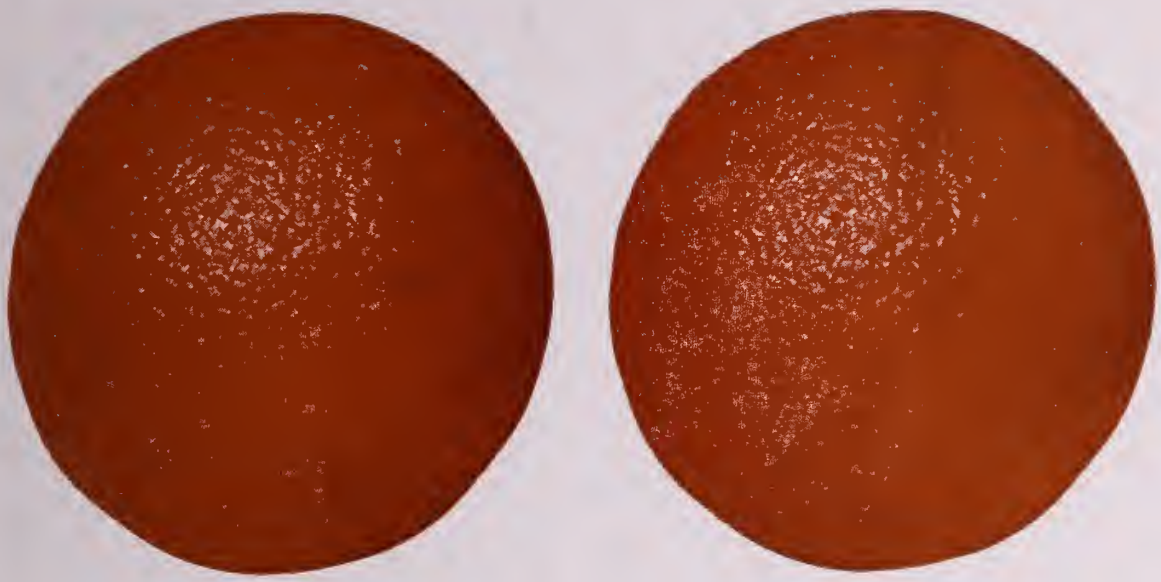
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The dosage is 1¼ grains per tablet. Mothers place such confidence in the Bayer name. And the new orange flavor is so fresh and smooth that children take it readily. (The grip-tight cap on the bottle helps keep them from taking it on their own.)

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Esidrix markedly increases output of sodium, chloride, and water and significantly reduces blood pressure. It has little or no effect on serum and plasma electrolytes, minimal effect on potassium excretion.

With Esidrix-K 50/1000 tablets, the problem of serious potassium depletion is even more unlikely. Two Esidrix-K 50/1000 tablets provide 2000 mg. of potassium chloride—the equivalent of 7 six-ounce glasses of fresh orange juice—with 100 mg. Esidrix. This is more "built-in" protection than is provided by any other diuretic-potassium combination tablet. Also available: Esidrix-K 25/500 tablets. For complete information about Esidrix and Esidrix-K (including dosage, cautions, and side effects), see current Physicians' Desk Reference or write CIBA, Summit, N. J.

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throughout the wide middle range of pain — control with one analgesic PERCODAN® tablets

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC)

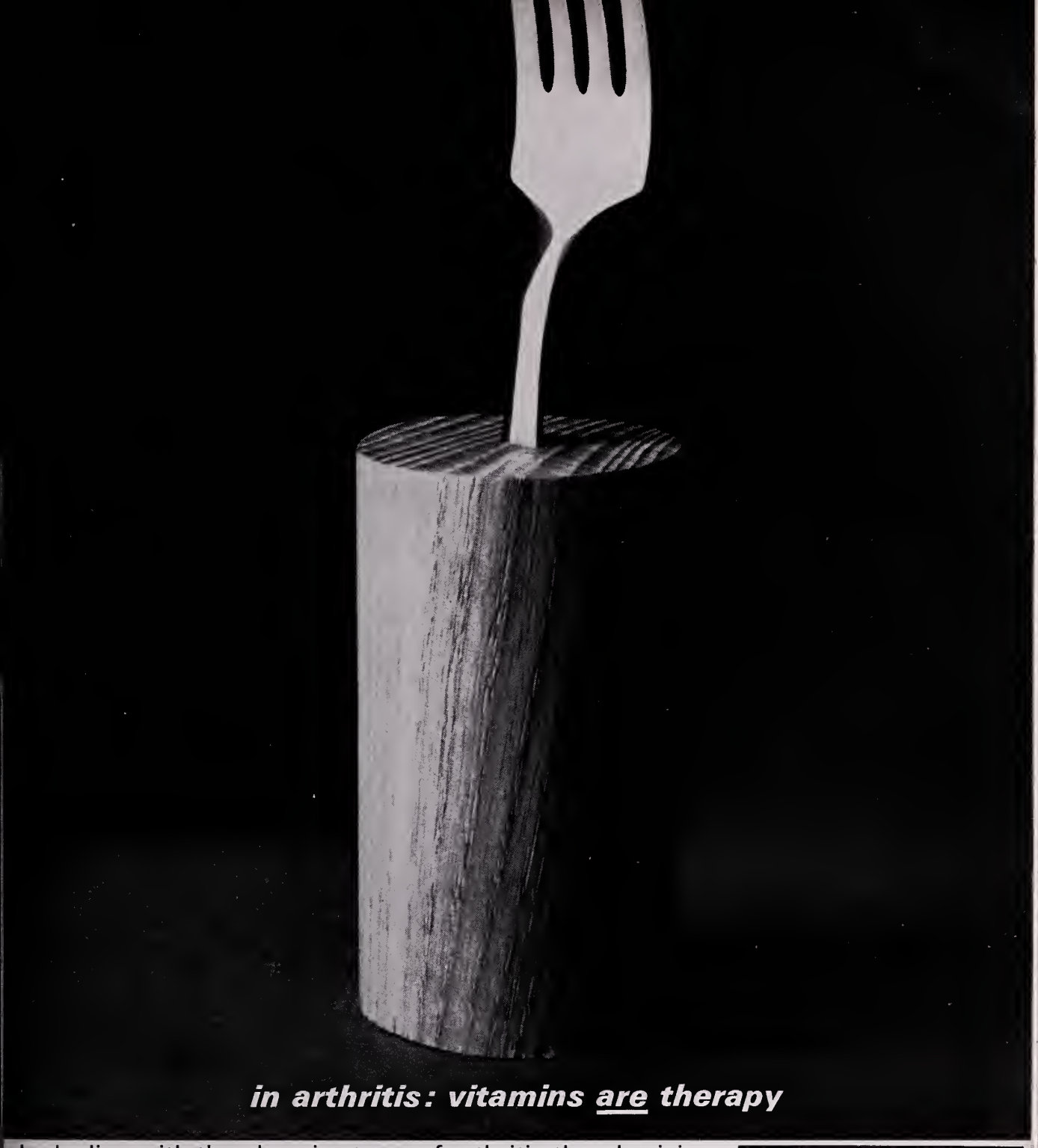
In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.



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in arthritis: vitamins <u>are</u> therapy

In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease. Supplied in decorative "reminder" jars of 30 and 100.

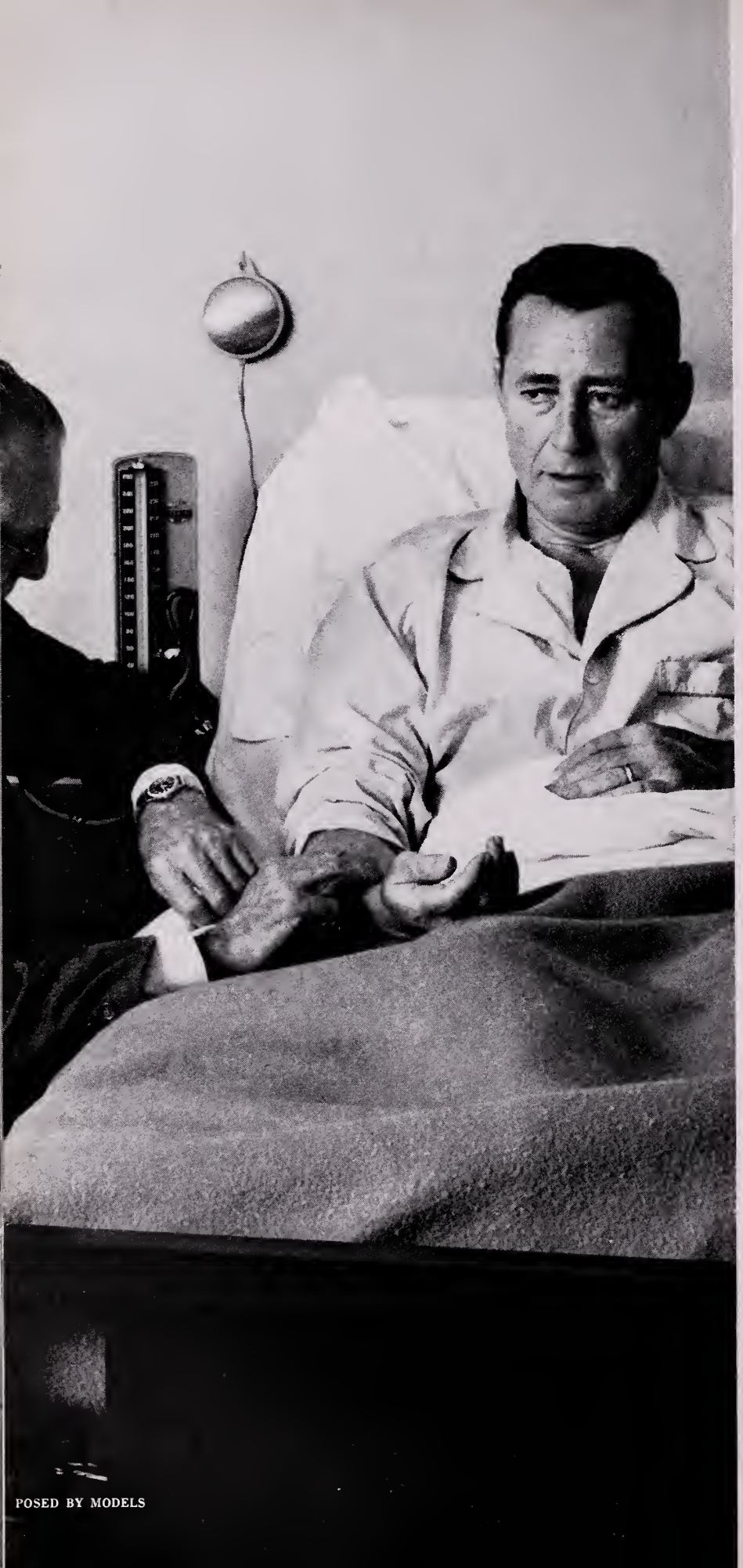
Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
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Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

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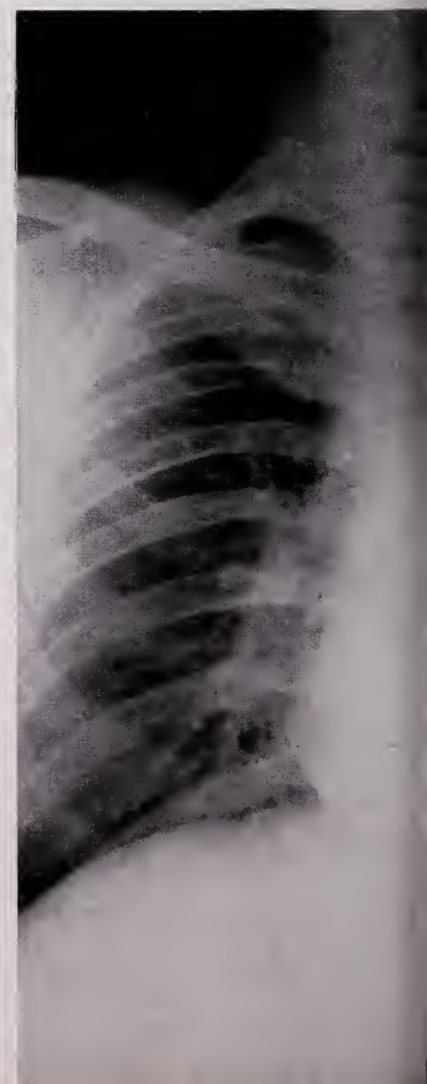
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in bronchitis—Considering the pattern of mixed bacteria, localized or diffuse involvement, potential underlying disease, and the need to allay symptoms and ease respiratory/cardiac function... physicians often include DECLOMYCIN demethylchlortetracycline in the course of therapy.

DECLOMYCIN produces activity levels higher than those of other tetracyclines... at lower dosage... and maintains them during the entire course of treatment without significant fluctuation.

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For *adults: Capsules*, 150 mg. and 75 mg. For *children:* cherry-flavored *Pediatric Drops*, 60 mg./cc., and cherry-flavored *Syrup*, 75 mg./5 cc. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

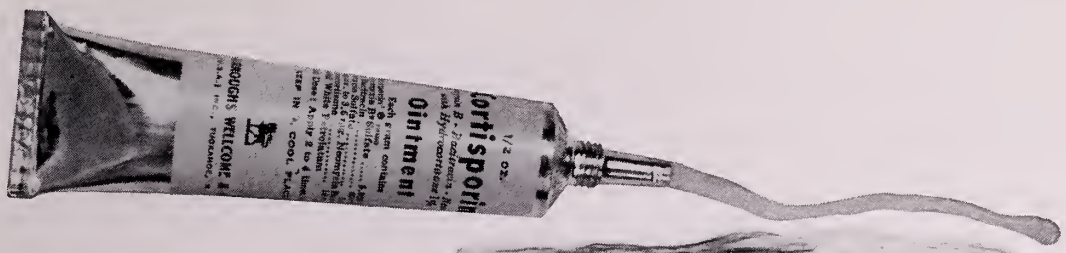
Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

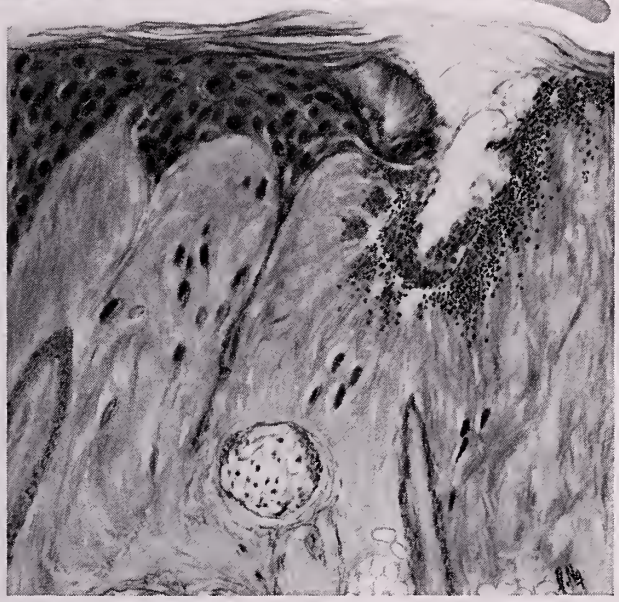
The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace

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for inflamed, infected, itching skin lesions

'CORTISPORIN'® brand OINTMENT

anti-inflammatory / bactericidal / antipruritic

- relieves pain and itching
- reduces inflammation and edema
- provides bactericidal action against most gram-positive and gram-negative organisms, including **Pseudomonas aeruginosa**
- rarely sensitizes

General Indications: Wherever inflammation or infection occurs and is accessible for topical therapy, as in burns, wounds, skin grafts; and plastic, proctologic, gynecologic, or general surgical procedures.

Dermatologic Indications: Atopic, contact, stasis, infectious eczematoid, and lichenoid dermatitis; neurodermatitis, eczema, pyoderma; anogenital pruritus; primary dermatoses with or without secondary infection; external otitis.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms.

Available: In tubes of ½ oz. with applicator tip and ⅛ oz. with ophthalmic tip. Although the ⅛ oz. tube is intended for ophthalmic use, it may be used topically.

Each gram contains:

'Aerosporin'® brand Polymyxin B* Sulfate	5,000 Units
Zinc Bacitracin	400 Units
Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base)	5 mg.
Hydrocortisone	10 mg. (1%)
Special White Petrolatum	q.s.

*U.S. PAT. NOS. 2,565,057 AND 2,695,261

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

from sodoku in India



to pharyngitis in South Dakota

there is a world of experience behind BRAND OF OXYTETRACYCLINE **Terramycin®**

Whether treating sodoku or a host of other infections, physicians throughout the world continue to rely on TERRAMYCIN for its outstanding safety, effectiveness and excellent tolerability. Not a single case of phototoxic reaction, blood dyscrasia or neurologic disturbance directly attributable to TERRAMYCIN has been reported in more than 3,000 clinical papers in the last 12 years. *In your practice, the next infection you see will very likely be "Terra-responsive."*

Sodoku is a synonym for the type of rat-bite fever occurring in the heavily populated Far East. The causative organism is *Spirillum minus,** a flagellated spirochete easily identified in dark-field preparations by its quick, darting motility. Besides the bandicoot,* indigenous to India and Ceylon, other rodents, ferrets and cats spread the disease. During the incubation period, which lasts from five to sixty days, the bite wound* heals, only to become inflamed and edematous with the onset of the acute stage. Fever, malaise, and a characteristic purplish maculopapular rash mark the eruption of the disease. Without treatment, relapses may recur periodically for four to six weeks.

**illustrated*

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Sioux Falls, South Dakota

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C. B. McVay, M.D. (1965) — Yankton
C. S. Roberts, Jr., M.D. (1967) — Brookings

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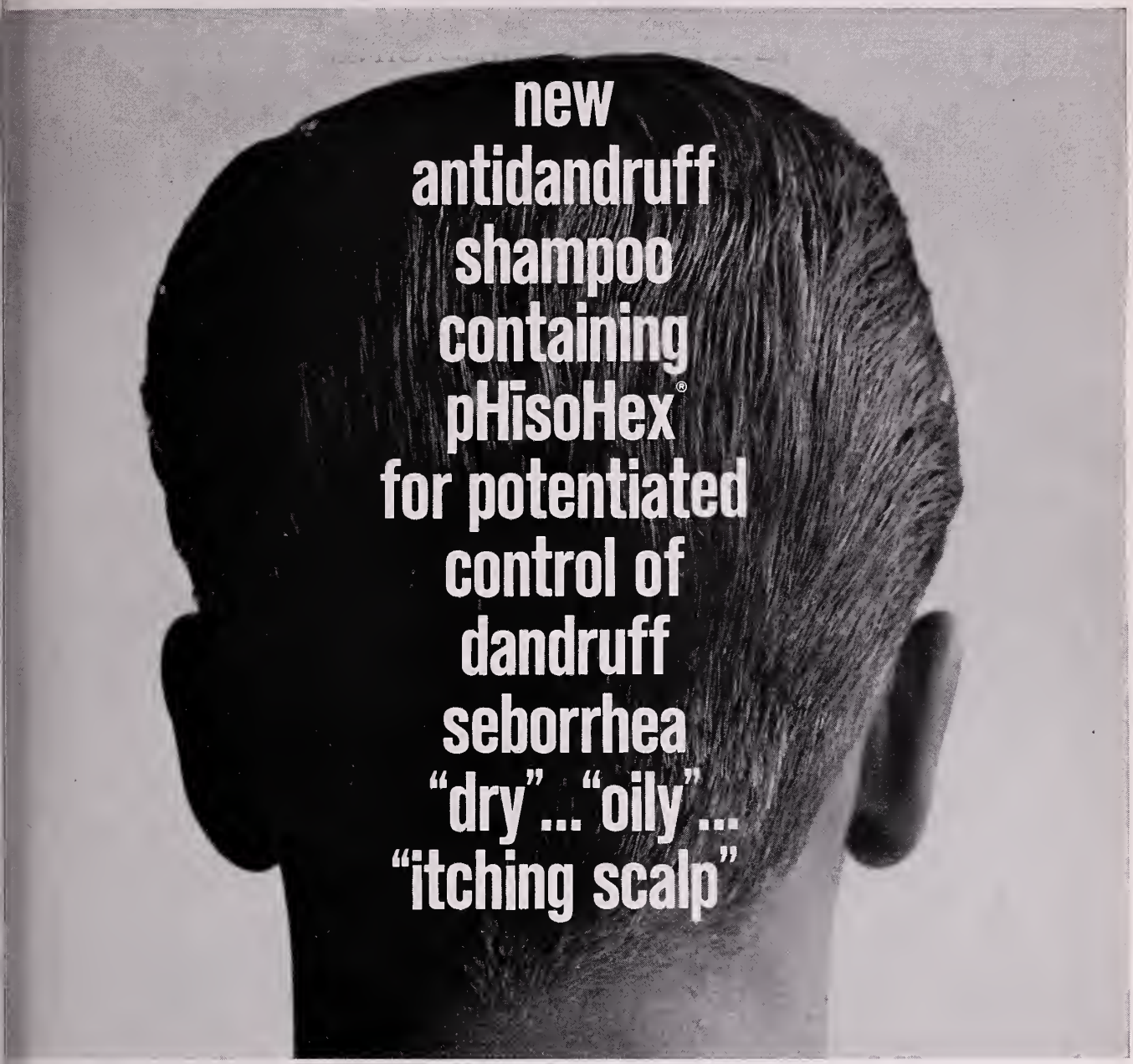
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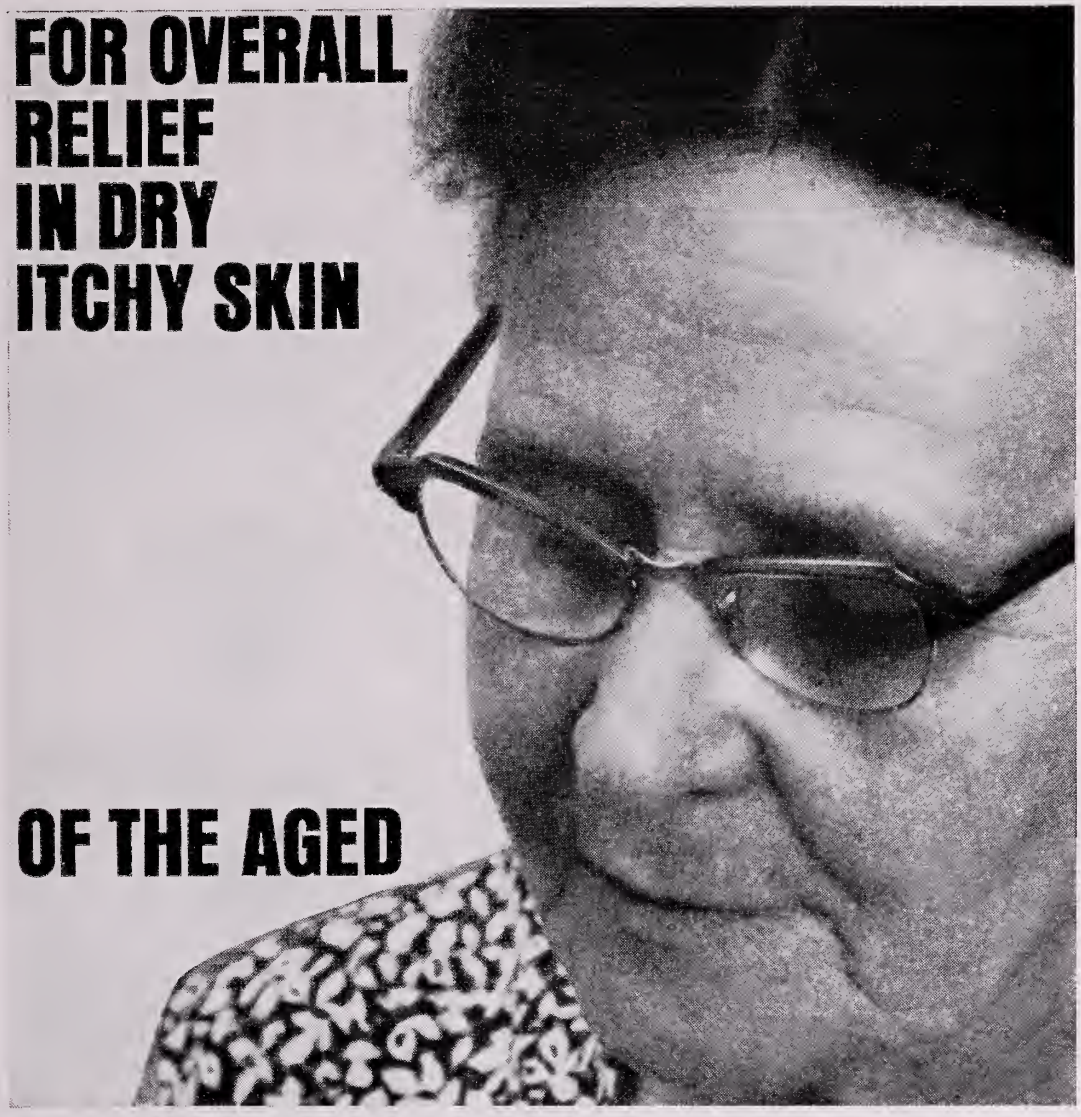
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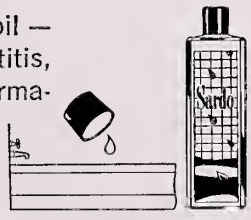
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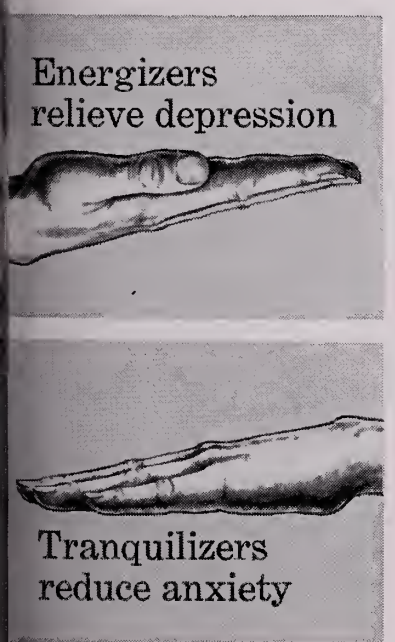
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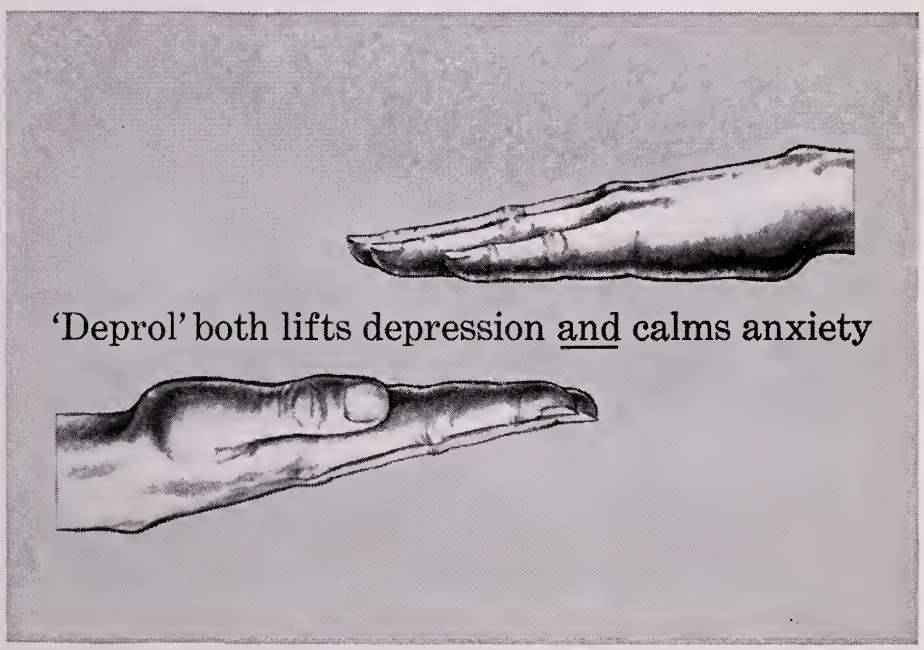
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ual Dosage: 1 tablet q.i.d. May be creased gradually, as needed, to 3 blets q.i.d.; with establishment of lief, may be reduced gradually to aintenance levels.

▲Deprol▲®

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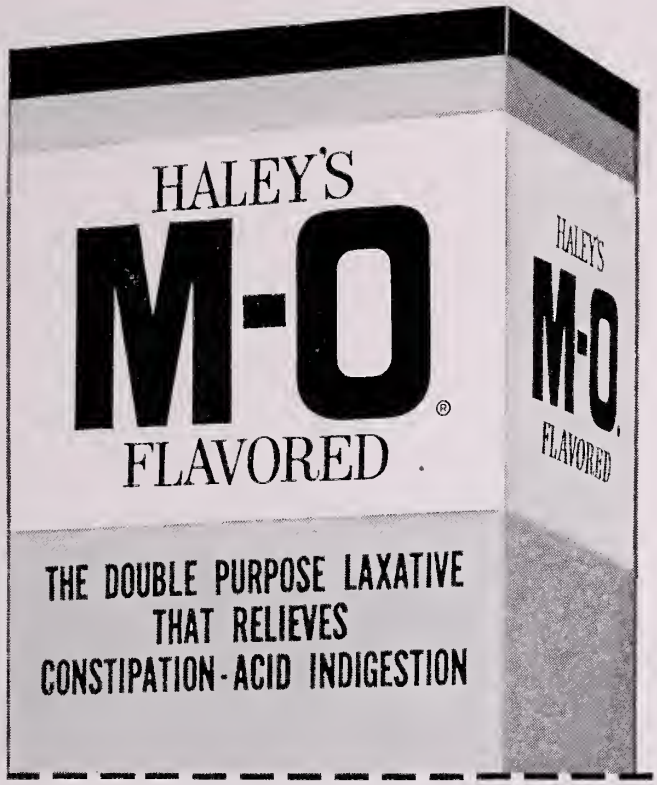
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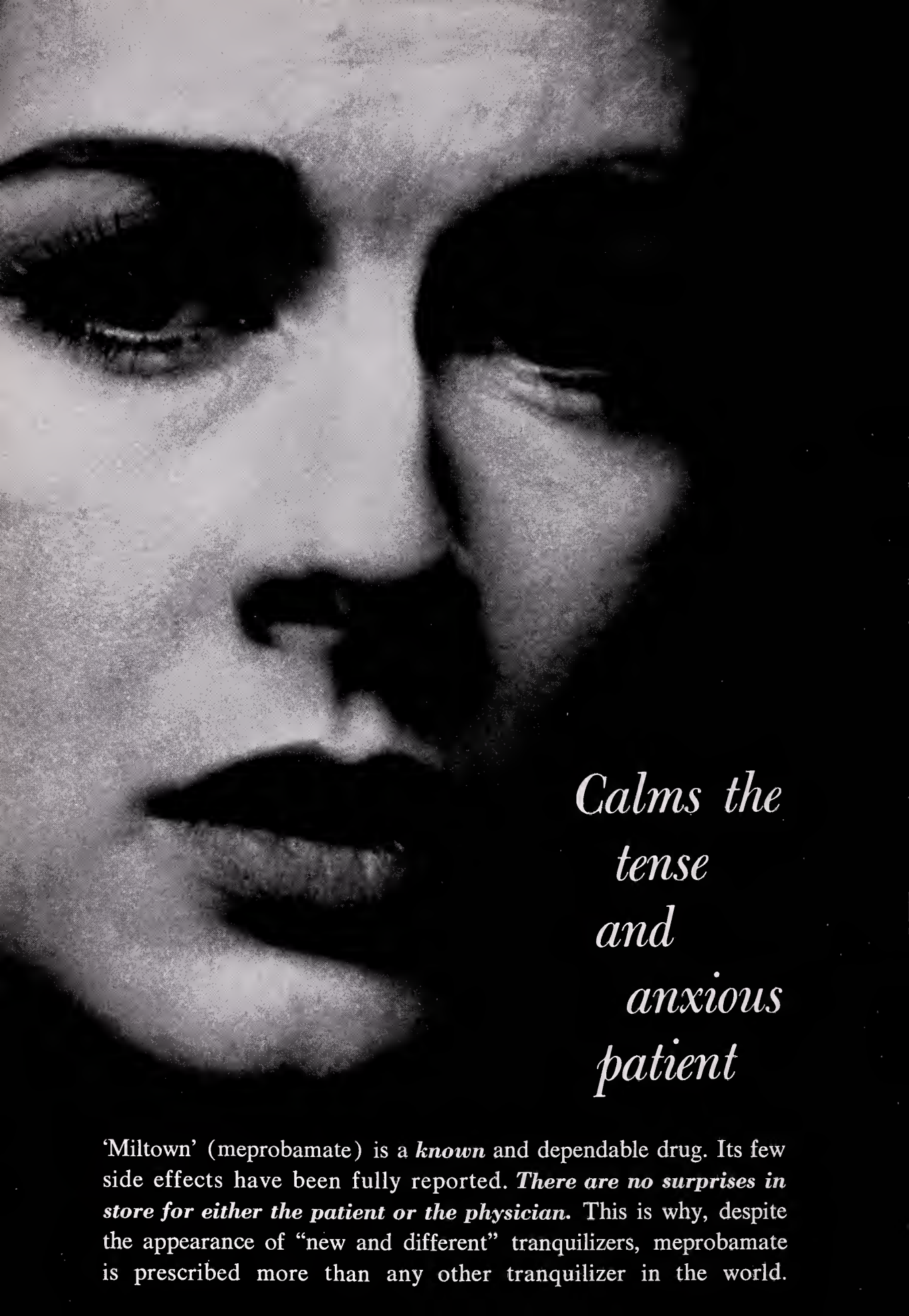
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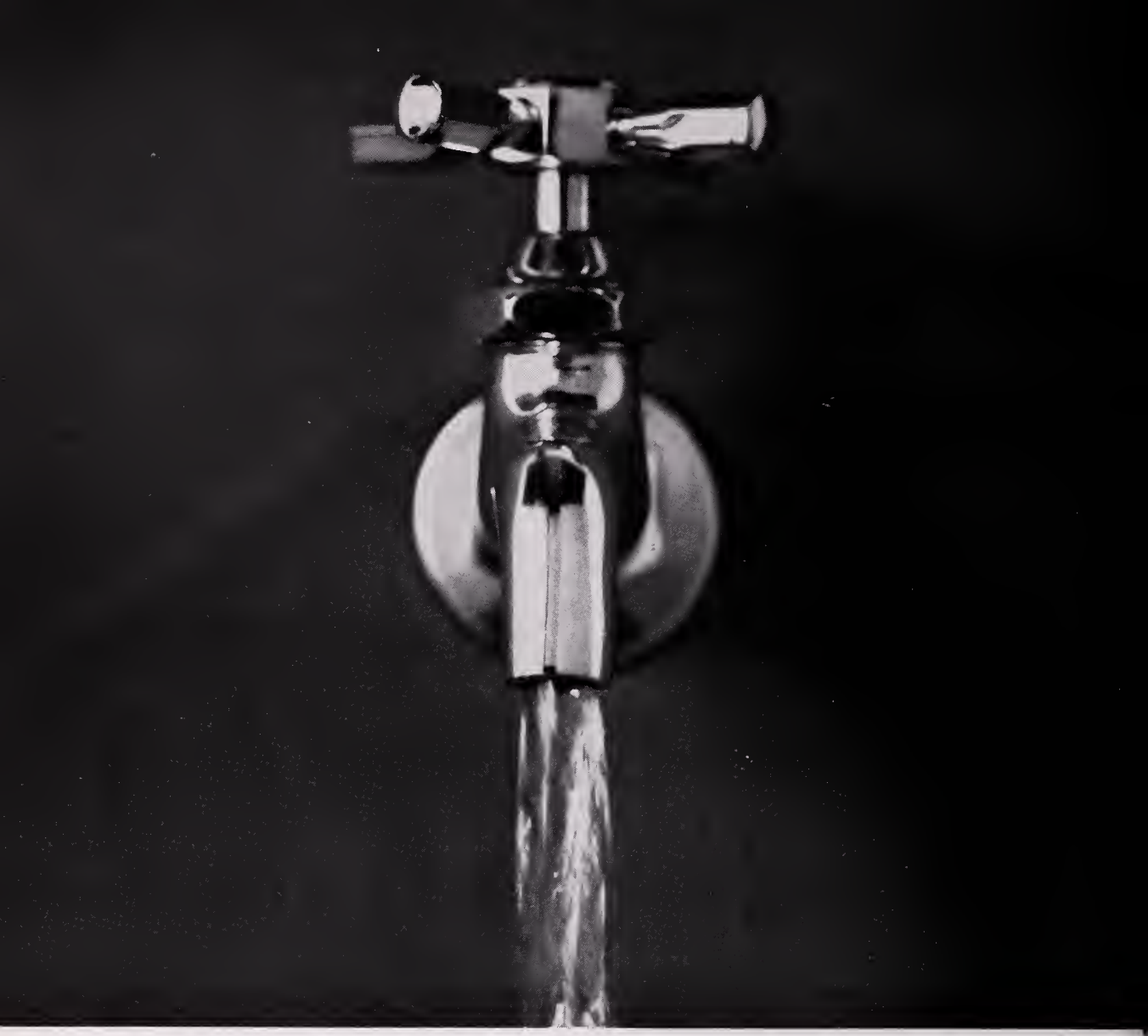
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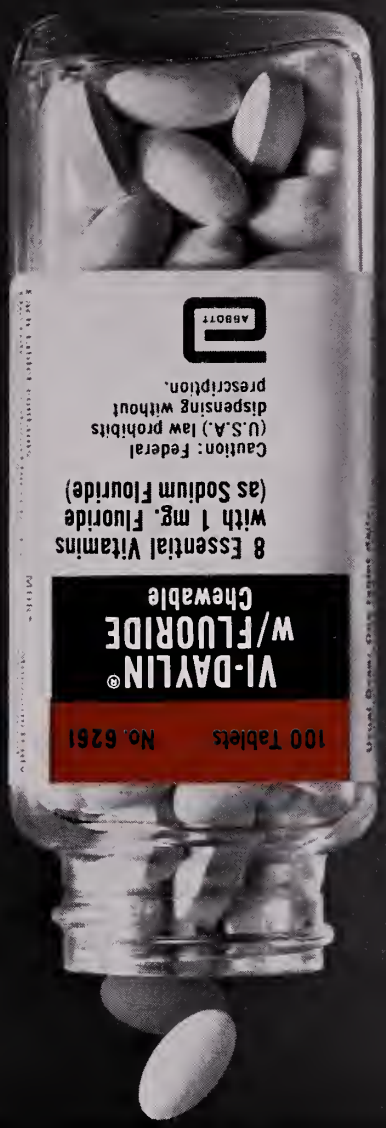
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1. Prescribing Supplements of Dietary Fluorides, Council of Dental Therapeutics, J.A.D.A., 56:591, April, 1958.
2. Fluoride Compounds, Accepted Dental Remedies, 27th Ed.:139, 1962.

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As a tranquilizer, TRANCOPAL (chlormezanone/Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers.[1] Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

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References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

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"Culture negative" after four weeks in this case of plantar tinea pedis

R. B., a 36-year-old writer, was first seen on November 5, 1962, with severe inflammatory tinea pedis involving the sole of the right foot. There was an 8-centimeter area of erythema, with vesicles, bullae and scales on the plantar surface of the foot. The lesion had been present for two weeks. Microscopic examination of scrapings showed hyphae, and cultures grew out *T. mentagrophytes.*

The patient was started on 0.5 gm. FULVICIN-U/F (griseofulvin, *ultra-fine*) daily. Three weeks later there was distinct improvement with only mild erythema and scaling present. After one additional week, therapy was discontinued and a second culture was negative. The patient was last seen on December 24, approximately three weeks after termination of therapy. At this time the skin was entirely normal in appearance.







1 Plantar tinea pedis before therapy.

2 After two weeks of therapy.

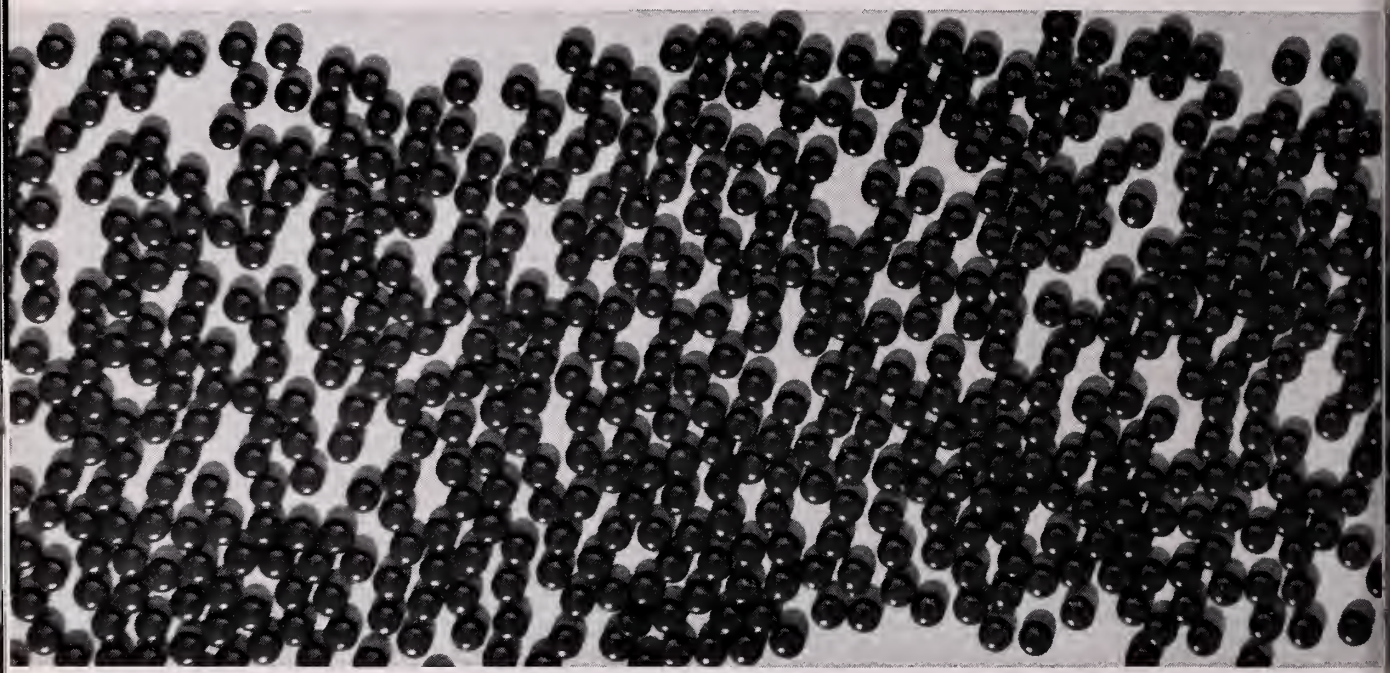
3 Six weeks later, skin essentially normal (two weeks after termination of therapy).

Clinical considerations: Although clinical studies with griseofulvin have not revealed evidence of serious toxicity, ***side effects***—as with any potent drug or antibiotic—may occur in some patients. An occasional minor decrease in leukocyte count has been observed, which was reversible when medication was discontinued. Occasionally, there may be heartburn, nausea, epigastric discomfort, diarrhea, lethargy, fatigue, psychomotor incoordination and, during the first week of therapy, headache. Studies are in progress to determine the safety of this drug during pregnancy; until the results of these studies are available, griseofulvin is contraindicated during pregnancy. ***Caution*** should be observed in patients with known penicillin-sensitivity. Should urticaria or drug rash develop, the drug should be withdrawn. ***Available*** in 125 mg., 250 mg. and 500 mg. scored tablets, bottles of 60 and 250.

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Basal Ganglia Surgery For Abnormal Movement Disorders*

Experience with 2,250 Cases

Stanley Stellar, M.D.**

Irving S. Cooper, M.D.***

For many years the surgical attack upon Parkinsonism had been based upon the premise that the pathways mediating abnormal movement disorders were identical with those carrying impulses for voluntary action. The focal points were, therefore, in various locations along the pyramidal tract and a partial paralysis was accepted as the price of relief. Following the same basic principle, Cooper,[1] in 1952, operated upon a case of post-encephalitic Parkinsonism with a view to alleviating tremor and rigidity in the right extremities by sectioning the left cerebral peduncle in the mid-brain (after Walker[2]). Profuse bleeding from a vessel, shown subsequently by means of cerebral arteriography to be the left anterior choroidal artery, required ligation of the vessel and forced termination of the procedure before the peduncle could be divided. To the astonishment of all of us who had the privilege of seeing this patient at New York University Hospital, there was immediate postoperative alleviation of the tremor and rigidity in the right arm and leg. This relief proved to be lasting. What is more, there was no weakness or paralysis of these extremities. This latter fact, as it turns out, has caused a quiet, although nonetheless important revolution in our concept of the neurological mechanism involved in hyperkinesias. While hitherto, it was widely held and almost universally taught that relief of involuntary movements could be obtained surgically only at the sacrifice of willed motor activity, this unique result shattered the foundation on which such an erroneous

*Presented at Joint North and South Dakota Medical Session, June 4, 1962.

**Professor of Clinical Neurosurgery, New York University Associate in Neurosurgery, Medical Center, N. Y. C., St. Barnabas Hospital, New York, N. Y.

***Director of Neurosurgery, St. Barnabas Hospital, New York, N. Y. Research Professor of Surgery, New York University Medical Center, N. Y. C.

tenet was based. A whole vista in neurophysiology was thus opened. This was the start too, of intensive new efforts on the part of many to relieve clinically disabled persons suffering from Parkinsonism; and later still, those incapacitated by Dystonia Musculorum Deformans, Intention Tremor of Multiple Sclerosis, Familial Cerebellar Tremor, Hemiballismus, Torticollis and the Intention Tremor of Wilson's Hepatolenticular Degeneration. The age of pyramidal tract section anywhere from cortex to cord, for the alleviation of involuntary movements at the expense of motor power was now past.

The surgical approach soon shifted to direct attack upon the key structures bathed by the anterior choroidal artery, namely, the mesial globus pallidus and the ventro-lateral nucleus of the thalamus. Prior work in this region of the brain paved the way. Of special importance are the contributions of Meyers,[3] Spiegel and Wycis,[4] Narabayashi and Okuma,[5] Fenelon and Thiebaut,[6] Guiot and Brion.[7]

The present report deals with results of surgery for involuntary movement disorders at St. Barnabas Hospital, New York. More than 2,250 operations have now been performed. The first 55 were anterior choroidal artery occlusion, the largest group being chemopallidectomies and chemothalamectomies. As of the present writing, more than 170 have been cryothalamectomies. Mortality and morbidity have steadily been reduced, the latest figures being 2.3% for mortality and 2.5% for lasting morbidity with chemothalamectomy, and zero mortality for cryothalamectomy. Another 7% have had transient complications. Deaths have resulted almost exclusively from hemorrhage, and bleeding has also been the most important cause of hemiparesis or hemiplegia. Intracerebral air cyst, now largely preventable, was responsible for temporary deficits in the early cases. Convulsive seizures occur infrequently, especially when anticonvulsant medications are employed prophylactically. Postoperative dyskinesias other than those

THE NEUROSURGICAL ALLEVIATION OF ABNORMAL MOVEMENT DISORDERS

Symptoms & Syndromes Amenable to Surgery (1952-1962)*

N = 2,210

Symptoms and Syndromes	Number of Operations		
	Unilateral	Bilateral	Total
Parkinsonian Tremor, Rigidity, and Deformities	1805	255	2060
Dystonia Musculorum Deformans	44	41	85
Cerebellar (Intention) Tremor	16	5	21
Intention Tremor of Multiple Sclerosis	5	3	8
Chorea and Choreathetosis	11	5	16
Hemiballismus	3	1	4
Torticollis and Retrocollis	7	2	9
Involuntary Movements of Wilson's Disease	2	1	3
Myoclonus and Multiple Tics	2	2	4
TOTALS	1895	315	2210

Figure 1 — These figures do not include cryothalamectomy operations.
*Through March 30, 1962.

for which surgery was performed, occurred in about 2.5%, but were transient in nearly all. Temporary disturbances of speech and balance were not unusual.

The results of operations have been most gratifying using chemothalamectomy. 80% have been relieved of tremor and 85% have had excellent alleviation of rigidity on the side for which surgery has been performed. With cryothalamectomy, the figures were 90% for tremor and rigidity. The second side has generally been done in bilateral cases six months or more after the initial operation. Re-operation for the same side has been necessary in about 10 to 15% within the first few days or weeks when imperfect lesion placement has yielded only a transient effect. Well-placed lesions have resulted in permanent cessation of tremor and rigidity. (Figures 1 and 2).

Although the ideal candidate for surgery is a young patient with unilateral symptoms, age alone is not crucial in determining the outcome, and numerous cases with bilateral symptoms have been treated successfully. The best candidates have an even better chance of good results with less chance of mortality and morbidity than given above in the average figures cited. Duration of the symptoms is also unimportant unless it has resulted in secondary changes, such as lack of schooling or job training, with poor motivation. These factors militate against rehabilitation of the patient. Contraindications include vegetative symptoms when marked, difficulty in speech and swallowing and above all, bradykinesia without much tremor or even rigidity.

The underlying principle of the surgical technique is simply the production of a destructive lesion in the ventro-lateral nucleus of the thalamus on the side of the brain opposite to the limbs whose tremor and rigidity are being treated. A reversible physiological interruption was, until recently, obtained by the concussive effect of an inflated balloon carried by a special cannula into the brain on a guide. This operation of chemothalamectomy has now given way to cryothalamectomy, whereby a liquid nitrogen carrying cannula with its tip at a temperature of minus 196° Celsius is substituted for the balloon cannula. The guide is first fixed to the head and the cannula is aimed for the target using external landmarks. The aim is corrected by internal landmarks shown roent-

THE NEUROSURGICAL ALLEVIATION OF ABNORMAL MOVEMENT DISORDERS

Results (1952-1962)*

N = 2,060

	Anterior Choroidal Artery Occlusion N = 55	Chemopallidectomy N = 735	Chemothalamectomy N = 1170	Cryothalamectomy N = 170
Abolition of Tremor	60%	60%	80%	90%
Abolition of Rigidity	70%	75%	85%	90%
Transient Complications**	16%	12%	7%	3%
Lasting Complications***	10%	3%	2.5%	1%
Mortality	10%	3%	2.3%	0%

Figure 2 — This table depicts the evolution of basal ganglia surgery.

*Through March 30, 1962.

**Includes changes during first two postoperative weeks in sensory, motor, psychological or speech function.

***Includes long standing paralysis, paresis, sensory, speech and mental changes.

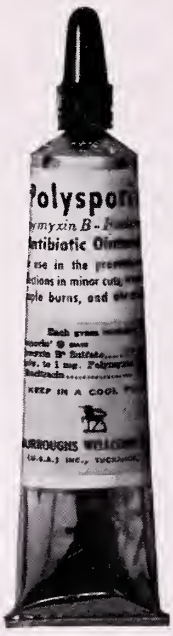
genographically using air in ventricles for contrast. The method of air encephalography is employed and the chief anatomical landmarks are the ventricles themselves, the foramen of Monro and the pineal gland. The lesion is made permanent by the later addition of absolute alcohol or by prolonging the freezing time with the liquid nitrogen.

The technique of cryothalamectomy has now completely replaced previous methods. The expectation that this would reduce the mortality from operative hemorrhage to a point as close to zero as possible seems to have been realized in the first 170 cases. Although Figure 2 shows only 100 cases of cryothalamectomy, there has also been no mortality in the additional 70 cases operated upon since that table was compiled. Animal experiments, as well as experience with brain tumors give further support. The reduction of the possibility of operative hemorrhage to these low levels makes it possible to offer basal ganglia surgery for abnormal movement disorders to a wider range of patients disabled by these distressing diseases.

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8. St. Barnabas Hospital Medical Bulletin, Vol. 1, No. 3, Spring, 1962.

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The McKennan Hospital Clinical–Pathological Conference

Concurrent Progressive Deafness, Nephritis and Outer Lens Disease.

CASE PRESENTATION

A seven and one half year old boy's ears were evaluated in November 1949 because of impaired hearing bilaterally, gradually progressive, for four years. There was no history of ear infections, head injury, excessive noise exposure, known contact with neuro-toxic chemicals, familial hearing loss, other disease or factors which might have caused or accentuated the hearing loss. He had noted no tinnitus or vertigo. At three years of age an infected node had been drained in his left upper cervical area. For some time he had had "kidney trouble," consisting of albuminuria and red and white cells in the urine, for which T & A had been done elsewhere earlier in 1949.

Examination showed a moderate amount of residual adenoid tissue in the nasopharynx but no structural abnormality in the nose, throat or ears. Hearing in each ear: Whispered voice — 3 feet, Spoken voice — 24 feet. An audiogram one month later (See Figure ♯1) showed hearing loss of moderate degree, primarily inner ear type. Because of mild eustachian tubal obstruction complicating inner ear deafness, he was given radiation to the nasopharynx. There was temporary improvement in the hearing thereafter; but because he did poorly in school, a hearing aid was prescribed. Although follow up examination in November 1952 showed no change in the physical findings the audiogram indicated decrease in the hearing acuity bilaterally (see Figure ♯2). Further audiograms

in 1955 and 1956 showed no apparent progression of the hearing loss.

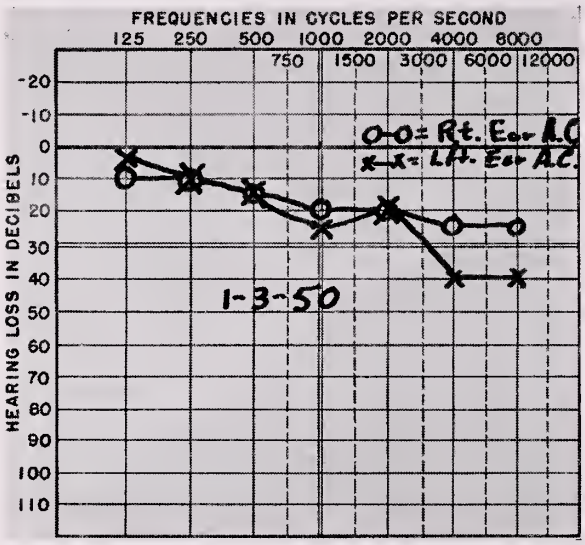


Figure #1) Audiogram done January 3, 1950 showing mild hearing loss bilaterally.

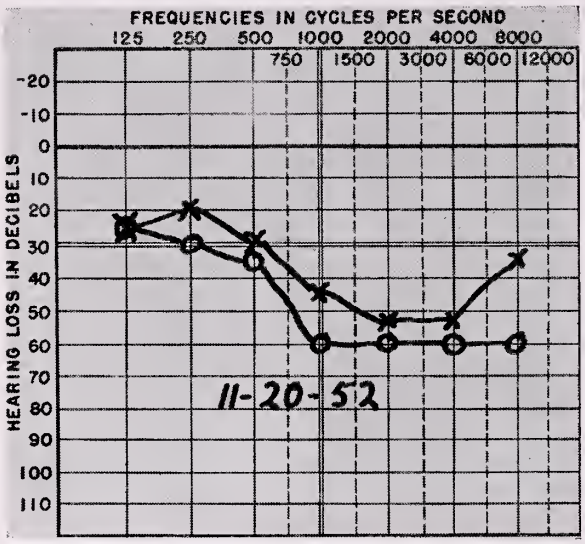


Figure #2) Audiogram about three years later showing progression of the hearing loss bilaterally.

In February 1955 he was seen because of "inflammation of the right eye" for four weeks, worse during the preceding four days, and poor vision in this eye for three months, gradually decreasing in acuity. There was the vague history of a light blow to the right side of his head in a baseball game about the time of onset of the eye complaints, but no other trauma to the eye or to the head. Recent general health had been good. Examination showed slight circumcorneal injection of the conjunctiva on the right but no evidence of external disease of the eye. The right pupil was irregular and through the slit lamp a small hole could be seen in the anterior lens capsule, just below its midportion. Through the hole, lens substance was extruding in to the anterior chamber of the eye (see Figure #3). The intraocular tension was normal.

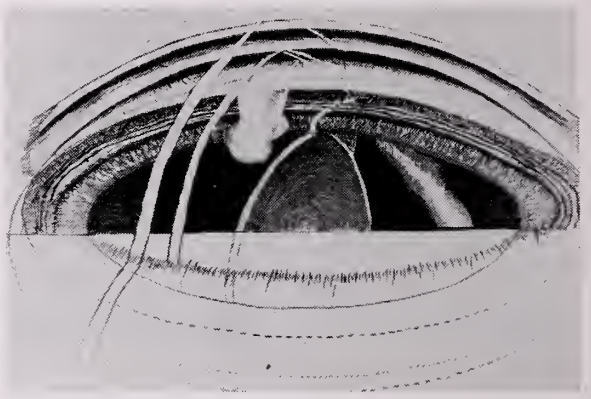


Figure #3) The artist's concept of the slit lamp appearance of the right eye as seen from above showing lens material extruding into the anterior chamber.

Vision on the right was limited to counting fingers. The left eye was normal with visual acuity of 20/30, corrected to 20/20 by Sph. -1.00, cyl. -.50 x 0. One week later the right anterior chamber was filled with lens material. This was aspirated following which the eye improved markedly. Three weeks later acute iridocyclitis developed suddenly but the intraocular tension remained normal. On cortisone and atropine there was rapid improvement so that by April 20, 1955, the eye was asymptomatic and the vision with an aphakic lens was 20/20. Vision in the left eye remained 20/30 without correction. Four months later a few small epithelial islands were forming opacities on the anterior vitreous surface of the right eye, with slight decrease in visual acuity.

In August 1956 the patient noted slight, increasing, blurring of vision in the left eye. There was no injury to the head or to the eye and no recent illness. Examination revealed a small, circumscribed bleb protruding from the anterior surface of the lens of this eye, about at its anterior pole. (See Figure #4). This appeared to be loculated fluid between the anterior lens epithelium and the basal membrane. The left fundus could not

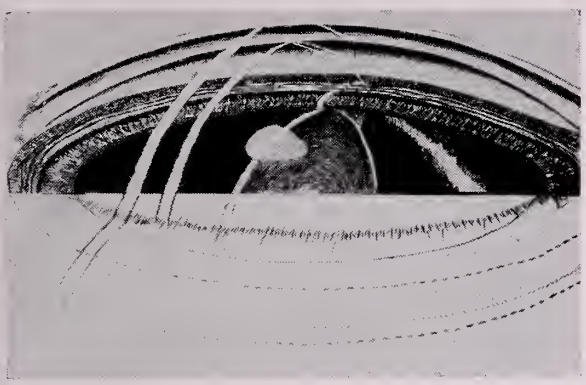


Figure #4) Schematic illustration showing the appearance of the bleb on the anterior surface of the left lens as seen from above.

be visualized. No other structural abnormality was present and the right eye was unchanged. Vision on the left was 20/200, corrected to 20/50 by sph, plus 3.25. Near visual acuity was reduced to 14/42. (It is notable that there was a change in refractive error of 4.25 diopters in the left eye in an eighteen month period indicating a loss of accommodation of the lens, and suggesting an organic change in the lens capsule). The vesicle on the left anterior lens surface remained under observation, for about three months. By February 1957 the bleb was flat and an anterior polar cataract was forming. Follow-up examinations showed this cataract to gradually increase in size so that by February 1958 the entire midportion of the anterior surface of the lens was involved. (See Figure #5). Visual acuity at this time was 20/40 -3 with a sph. plus 3.25. The right eye had remained essentially unchanged, the best visual acuity being 20/200. Subsequent examinations in 1958 and 1959 showed no change in the eyes or the vision and hearing remained unchanged. On no physical examination was any other structural or functional abnormality found. The boy was of average intelligence and, other than the problem previously discussed, seemed to grow and develop in a normal manner. He had made good adjustment to the multiple anomalies.

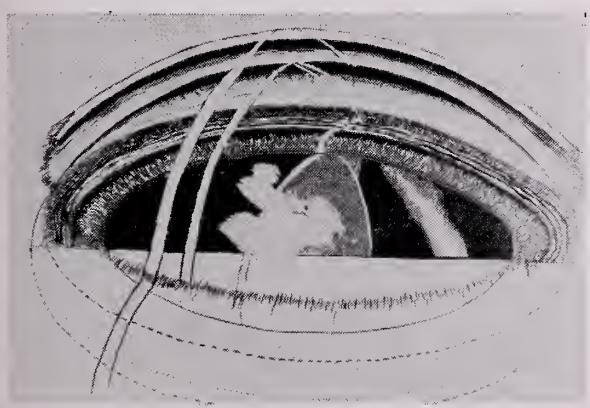


Figure #5) Schematic illustration of the appearance of the anterior polar cataract.

His general health was good until February 1960, at which time he was hospitalized because of hematuria, malaise, slight temperature and failing vision. Urinalysis showed 4 plus albumin, 100 RBC/HPF and granular casts. Blood urea nitrogen was 60 mgm% on admission and went to 299 mgm%. Blood pressure was 220/130, but decreased somewhat on antihypertensive therapy. The clinical course was one of progressive deterioration with increasing renal failure which soon resulted in death.

DISCUSSION: J. B. Gregg, M.D.
(Otolaryngology)

In opening the discussion of this most unusual and interesting case, I refer you to the protocol. Further elucidation concerning the history is superfluous. There was nothing really characteristic about the clinical course of the hearing loss, a progressive inner ear type deafness. It resulted in sufficient social inadequacy that he eventually required amplification, with which he was well compensated. The deafness must be presumed to have been congenital or due to some unrecognized effect during childhood.

S. F. Becker, M.D. (Ophthalmology). The circumstances discussed here are unusual not only because there was the combination of cochlear, ocular and renal disease which progressed with time, but more especially because of the unusual manner in which the eye pathology appeared and developed. Spontaneous rupture of the ocular lens in a young person without significant trauma or other precipitating causal factor is in itself uncommon. It has been reported to occur in Hallerman-Streiff syndrome, Rothmund syndrome and in Marshall's syndrome, in hydrocephalic epilepsy, with retrolental fibroplasia and occasionally with degenerative changes in the lens from other causes. In this case the progress of the eye in which the lens ruptured was not unpredictable. However, in the other eye the fact that a lens opacity orig-

inated in a fluid filled vesicle beneath the anterior epithelium of the lens, was apparently resorbed, and then formed an anterior pole cataract, was most atypical. The hypothetical question arises as to whether the pattern followed by the second eye was similar to that of the first eye which was not observed until after spontaneous rupture of the anterior lens capsule, differing in that the bleb on the lens surface did not rupture into the anterior chamber. The questionable history of mild trauma to the first eye to be involved was probably an unrelated happenstance, because the actual eye difficulty was not really noted until some time after the trauma.

C. W. Ihle, M.D. (Pediatrics) My brief and isolated contact with the patient being discussed hardly qualifies any conclusions but the early history may be of some value as to age of onset.

He was sent in by the family physician at age seven years for an intravenous pyelogram. Information obtained at that time revealed that he had contracted measles at the age of one year followed immediately by chickenpox, and was ill for about one month. Urinary frequency and dysuria were noted but there was no gross hematuria or edema. Three years later, at age 4 years, they consulted the family physician and urinalysis revealed albumin, red and white cells. Medication was given with no improvement. The parents also felt that there had been progressive loss of hearing since the measles at age one year.

Laboratory work in February 1950 revealed Hgb 84%, RBC 4,400,000, WBC 7,800 normal differential. U/A — specific gravity 1.009, reaction 6.5, albumin 1 plus, sugar negative. I.V.P. normal.

D. L. Greenfield, M.D. (Urology) This boy was first seen by me in March 1955, and as is the case in the majority of patients with this condition, showed no specific diagnostic anatomical findings in his urological work-up, which included cystoscopy and pyelography.

This syndrome of hereditary nephropathy with deafness is caused by a renal lesion closely resembling glomerulonephritis, with pyelonephritis frequently superimposed and leaves little to be detected on gross urological examination. If foam cells are present in the kidney, they can not be detected without tissue being obtained for microscopic examination.

The increasing use of renal biopsy will help us in earlier and more exact diagnosis of this condition. However, it must be remembered that foam cells are not necessarily limited to patients exhibiting the pathology found in this abnormality.

Several of us are at present following another family probably demonstrating this syndrome which may be a sex influenced dominant trait. One brother has expired and another is being followed with very complete laboratory studies.

V. K. Cutshall, M.D. (Internal Medicine) This 17 year old boy had a long case history of glomerulonephritis, first picked up at age 7. He had had consistent hematuria since his original nephritic episode. When I first saw him he was quite anemic, 9 gr. hemoglobin. His urine showed 2+ protein with granular and hyaline casts. His blood urea nitrogen was 60 mg% and there was a moderately severe hypertension ranging from 200 to 210 over 110.

His course in the hospital was gradually downhill accompanied by a steadily rising BUN which resulted in a terminal uremic death. His hemoglobin dropped to 5.3 gm. and his blood urea nitrogen was 299 mg% the day before death. From the internist's standpoint he died a typical chronic glomerulonephritis death with terminal uremia and hypertension.

NECROPSY FINDINGS: T. R. Anderson, M.D. (Pathology)

POSTMORTEM EXAMINATION: The significant gross pathological findings were as follows: hydrothorax, bilateral (150-200 cc.), ascites (150-200 cc.) cardiomegaly (510 gm.), pulmonary edema, and chronic nephritis. The right kidney weighed 110 and the left kidney weighed 125 gm. Capsules of the kidneys stripped with difficulty, and revealed a diffusely granular and pitted cortex in which were foci of petechial hemorrhages. On cut section of both there was evidence of diffuse narrowing of cortices. Calyces and pelves were surfaced by smooth, pinkish-white mucosa without evidence of gross abnormalities. The right lung weighed 1180 gm. and the left lung weighed 500 gm. On cut section moderate quantities of slightly sanguinous fluid

exuded. There was hemorrhagic discoloration of pleura over the posterior aspects of both lower lobes of lungs.

MICROSCOPIC EXAMINATION: Sections of lung disclosed marked hyperemia of pulmonary vessels and septal capillaries with pink-staining fluid and erythrocytes within distended alveolar spaces. A number of alveoli were lined by hyalin membranes. In focal areas of lower lobes, alveoli were partially occluded by organizing fibrous tissue in which were a scattering of leukocytes, including neutrophils, plasma cells and lymphocytes. Sections of kidney disclosed diffuse scarring of cortex with evidence of glomerular fibrosis and crescent formation. Many glomeruli were represented by hypocellular and hyalinized fibrous masses. Others showed partial obliteration of Bowman's space as result of proliferation of epithelium and fibrous tissue. Some were a scattering of eosinophils and lymphocytes. Distal convoluted tubules and collecting tubules contained hyalin and granular casts. Pelvic epithelium was essentially unchanged. There was no evidence of fat-filled macrophages within kidney.

The histological changes were considered to be consistent with chronic glomerular nephritis, resolving bronchopneumonia, congestion and edema of lungs. Changes of cardiomegaly, hydrothorax and ascites, which were described grossly, were considered secondary to the patient's nephritis.

EYE AND INNER EAR PATHOLOGY: J. B. Gregg, M.D. Sections through the inner ears showed evidence of degeneration of the stria vascularis and the hair cells, especially in the basal coil of the cochlea. The spiral ganglion cells did not show any apparent degeneration. The basal membrane, Reissner's membrane and other structures of the cochlea and vestibular labyrinth were not abnormal (See Figure ♯6). Histological examination of the left eye showed pathological findings which were confined to the lens. There was an anterior polar cataract which was composed of hyalinized material surrounded by a single layered epithelium on its anterior and posterior surfaces. (See Figures ♯7, ♯8). The epithelium was composed of flattened cells which split into two layers at the cataract's edges. At the periphery of the cataract the capsule in one area was several cells thick, suggesting a reduplication of the epithelium. The lens fibers immediately underlying the cataract appeared degenerate and partially decomposed. The remainder of the lens and the eye were normal. The eye findings were interpreted by the Ophthalmological Pathologist, Doctor Frederick Blodi of

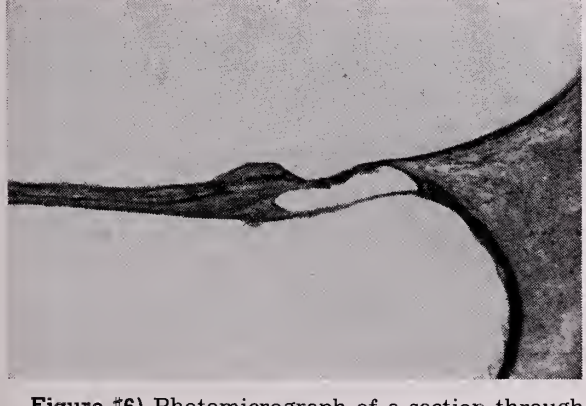


Figure ♯6) Photomicrograph of a section through the basal coil of the cochlea (X 100) showing degeneration of the stria vascularis and the hair cells.



Figure ♯7) Photomicrograph showing the anterior polar cataract with reduplication of the lens epithelium on both surfaces and degeneration of the underlying lens fibers. (X-100)

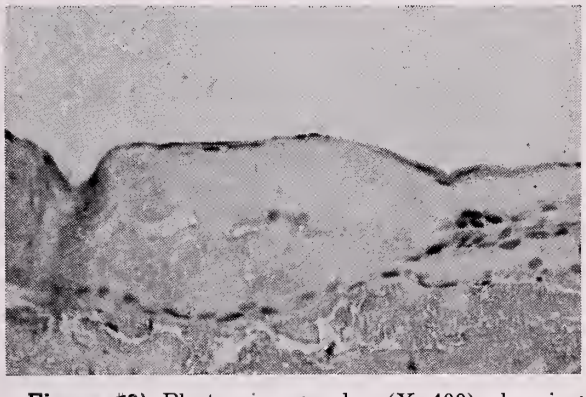


Figure ♯8) Photomicrography (X 400) showing the midportion of the "reduplication cataract."

the University of Iowa, as a congenital or juvenile cataract.

CLOSING COMMENTS: J. B. Gregg, M.D.

We do not presume to give to you answers for all of the questions which are posed by this case. Concomitant ocular lens abnormalities, deafness and chronic nephritis occurring as a syndrome in the same individual has been reported on at least seven occasions in the past. In this case, the eighth, the most complete evaluation has been obtained. Several things found here differed from previously documented cases. The manner of development of the cataract was that first reported by Treacher Collins, in the English literature some time ago, under the name of "reduplication cataract." Contrary to the opinion of Collins and others, this boy's cataract did not develop in utero but appeared at 13 years of age. This would suggest that these cataracts may have toxic or other precipitating factors which stimulate their development from unrecognized congenital rests.

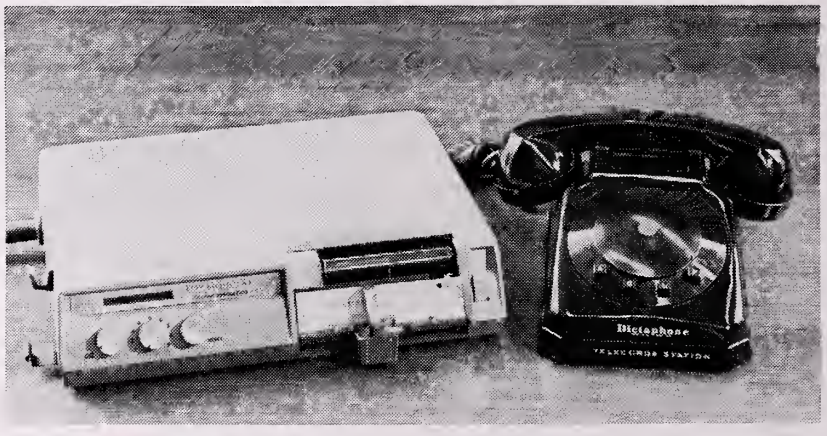
In this case there was found no inherited, traumatic, metabolic, hormonal or other causative factors for the disease complex. Investigation of the other cases which are reported has not revealed any constant cause for the triad of diseases together in the same individual. Although ectodermal dysplasia has been hypothesized as causative for a similar symptom complex, the renal involvement here is unexplained because the kidneys are not of ectodermal origin.

This case will be reported in greater detail in a coming issue of the Archives of Ophthalmology.

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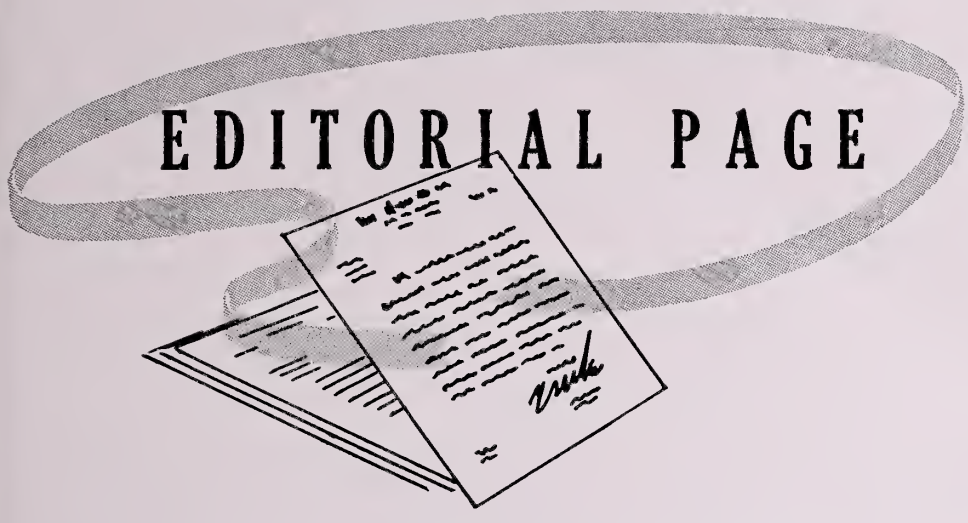


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MINERS MAY BREAK UP HOSPITAL CHAIN

Coal industry slump prompts UMW to rescue welfare and retirement plan by turning some facilities over to local communities in mountain states.

The United Mine Workers' controversial system of coal-area hospitals is about to undergo some critical changes.

For six years the UMW has operated ten of these facilities in the mountains of Kentucky, Virginia and West Virginia. The experiment in group medical care stirred much debate but has generally been successful.

Hard times have now engulfed the coal industry. Royalties being paid into the UMW Welfare and Retirement Fund have fallen off. The beneficiary rolls have been virtually halved. Some of the hospitals face a sharp cutback in use.

As a result, the fund has reluctantly begun negotiations to turn over to communities four hospitals in Kentucky—Middlesboro, Hazard, Whitesburg, and McDowell. And it is bringing patient beneficiaries from other states to help maintain full utilization in the other hospitals.

Kentucky Gov. Bert T. Combs has called all interested groups to attend a meeting next month in an attempt to work out arrangements for communities to take over the four Kentucky hospitals with state and possibly federal help.

The UMW launched its hospital system in 1956 because it believed that adequate medical care could be provided in no other way in the remote mining towns served by the welfare program. Dr. Warren F. Draper, executive medical officer of the welfare fund, explained later that "many of the hospitals we had to use were so dilapidated and deficient they scarcely merited the name.

"While local physicians rendered the best service they could," he said, "it was apparent that an adequate number of physicians trained in modern techniques and specialist services could not be attracted to these areas until the necessary physical facilities were provided."

With the support of some medical leaders, and over the strong opposition of others, the welfare fund spent $30 million building a chain of ultramodern hospitals with a total capacity of more than 1000 beds. There were three so-called central hospitals and seven community or satellite hospitals all under the supervision of UMW officials in Washington.

Staff physicians were all permitted to treat emergency cases and to admit their own private patients when beds were available, but miners and their families had top priority.

Physicians in the community were invited to join the staffs — and many of them did. But the house staffs were composed almost exclusively of specialists from other areas because the UMW maintained that the top-quality men they needed were not available locally. For these and other reasons, some medical societies refused membership to UMW staff physicians.

For a while, the AMA cooperated with the

hospital program. But after Dr. Draper made a speech in 1958, charging widespread medical abuses in the treatment of miners, organized medicine struck back. Dr. F. J. L. Blasingame, then AMA general manager, questioned "the right or ability of one individual and his subordinates to determine arbitrarily who is qualified to provide medical care."

Dr. Blasingame termed the UMW medical care program "a controlled and highly paternalistic" system which denies the miners and their families the right of free choice of physicians.

Despite flareups in UMW-medical relations, the hospitals generally flourished. There were more than 400,000 bituminous coal miners fully employed and another 35,000 working part time. Royalties swelled the welfare fund to $150 million. In all, there were potentially more than one million medical care beneficiaries.

Even as the hospitals were developing their full potential, trouble was brewing. Competing fuels and automation were cutting deeply into mine operations. The daily work force slumped from 400,000 to a mere 175,000. Royalty payments fell by more than $30 million.

In a series of moves to meet the financial emergency, the miners' fund began curtailing benefits. Workers were told they would be eligible for hospital and medical care for only one year after being laid off their jobs (four years, if disabled). Previously, the fund provided full care without regard to the length of employment.

A further drastic cutback was disclosed this fall. Miners were notified that they no longer would be eligible for care if the companies they worked for were either not paying or delinquent in their royalty payments. Together with the earlier curtailment, this action cut the potential number of beneficiaries in half.

As a result, the hospitals are feeling a corresponding fall in admissions. The blow has been softened somewhat in the early months of the cutback by transfer of miner patients from other states where the union does not maintain any hospitals of its own. Where a patient's condition permits, and travel expense is economical, he is moved to one of the UMW units.

In the last fiscal year, more than 600 cases were referred to the hospital chain from 15 other states, including California, Utah, Colorado, Montana, Wyoming and Alaska.

But even this move could not assure full utilization of facilities in the face of the latest cutback order, and Dr. Draper's group had to face the prospect of a sharper drop in admissions in some of the smaller hospitals. As a result, they decided to transfer some of the most vulnerable Kentucky hospitals — Middlesboro (84 beds), Hazard (72), McDowell (60) and Whitesburg (90) — to the communities concerned. Whether other hospitals are also transferred later may depend on their degree of utilization.

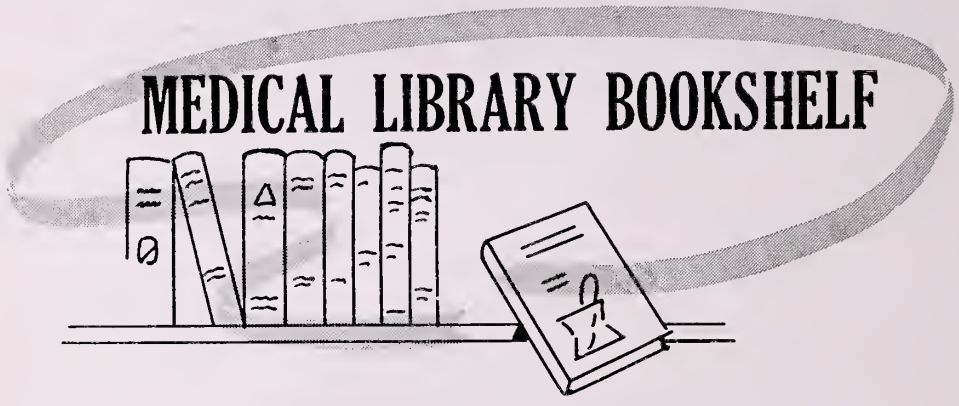
So far, two of the fund's central hospitals — one in Beckley, W. Va. (199 beds), the other in Williamson, W. Va. (150 beds) — have been well utilized, at about 80% of their capacity. The third central hospital in Harlan, Ky. (192 beds) has been reasonably well patronized and presumably would get more patients should the four other Kentucky hospitals be transferred out of the UMW system.

In fiscal 1962, the UMW welfare fund paid out $50 million in hospital and medical care benefits.

Despite the coal industry slump, royalty payments in fiscal 1962 amounted to more than $123 million.

Nevertheless, the fund is trimming its sails. A combination of rising medical care costs and declining income and beneficiary rolls is forcing a retrenchment in a pioneering experiment in hospital care that was being called "a bright new hope" only a little more than six years ago.

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MEASLES

According to the Minneapolis Morning Tribune for Friday, March 22, licenses have been approved by Anthony Celebrezze, Secretary of Health, Education and Welfare, for the manufacture of two types of vaccine for use in combating measles. Charles Pfizer was licensed to market the inactivated or "killed measles" virus vaccine and Merck, Sharp and Dohme the "live" virus vaccine. The licensing permits distribution through regular commercial channels and should be supplied in about a month. These vaccines are for protection against the common or red measles and not against German measles. Although this type of measles is classed as a benign infection, complications do occur, particularly encephalitis and measles cause more deaths than any other childhood disease.

Dr. John F. Enders, Chief of the Research Division of Infectious Diseases, The Children's Hospital Medical Center, Boston and Thomas C. Peebles of Harvard Medical School described the isolation of measles virus in tissue culture and its distinctive cytopathic effect, laying the basis for quantitative studies on propagation of the virus, estimation of antibodies and the production of attenuated viruses. (Proc. Exp. Biol. and Med. v. 86:277, 1954.)

The March 1962 issue of the AMA American Journal of Diseases of Children v. 103 is devoted to the papers presented at the International Conference on Measles Immunization held at the National Institutes of Health in November of 1961 and sponsored by the Department of Pediatrics of the University of Colorado School of Medicine. This issue is an extremely valuable source of information about various phases of measles with many of the papers having up to date bibliographies.

Surgeon General Luther L. Terry of the U. S. Dept. of Health, Education and Welfare in his opening remarks at this conference points out that the possibility of successful inoculation against measles was foreseen more than 200 years ago.

In a book entitled **Tentamen de Inoculanda Peste,** published in London in 1755, the author, a Hungarian physician, had this to say about a disease which "causes trouble to each mortal only once!"

"Concerning measles, there is no doubt at all that the experiment (inoculation) would be successful. But while the disease lasts only a very short time, no doctor thus far, insofar as I know, ever thought of preventing it with the aid of inoculation. . . . This disease is not as innocuous as is popularly believed, for sometimes, with certain combinations of causes, it becomes so epidemic that it causes a very great slaughter of the human race. . . . Wherefore, if it were easy to gain peace of mind from the institution of transmission of measles in the future, it would be useful to the human race."

It is only within recent years that medical therapy has assisted in lowering morbidity and improvement of medical care through the use of antibiotics and y-globulin to modify the course of the disease.

At the International Conference on Measles the six sessions and their presiding chairmen were: World Wide Importance of Measles, Dr. Abraham Horwitz; Measles Viruses, Dr. John R. Paul; Immunization of Man against Measles, Dr. Pierre Lepine; Immunization of Man against Measles, Special Studies, Dr. Edward B. Shaw; Problems of Production and Biological Control of Measles Vaccine, Dr. C. Henry Kempe; Future of Measles Vaccines, Dr. Preben von Magnus.

Conference papers were presented concerning measles in such countries as Brazil, Chile, South Africa and the U.S.S.R.

A paper presented by Dr. Edward Shaw on the Future of Measles Vaccine emphasized the importance of vaccination, the need of educating parents about the serious sequelae of measles, the preference of live or killed virus vaccine, and the importance of the physicians recording side effects, failures and successes of measle immunization.

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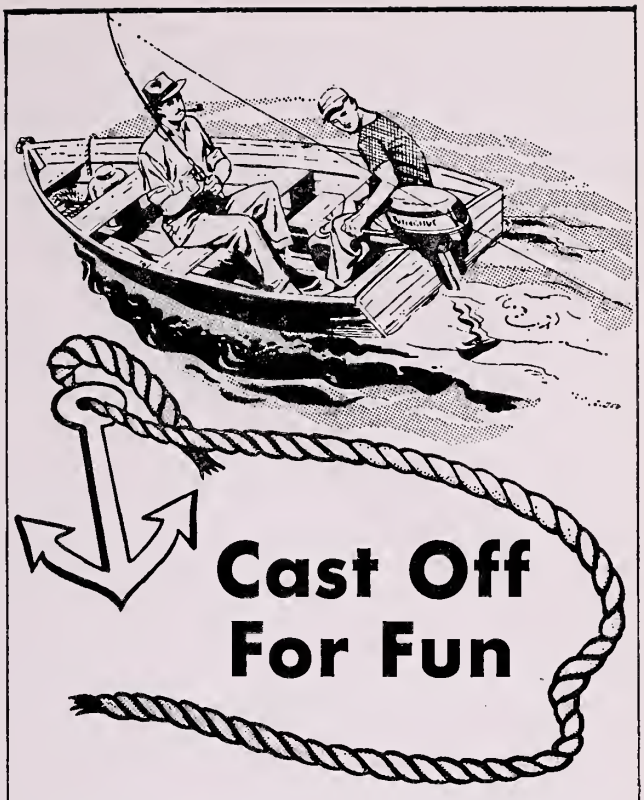
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NEWS NOTES

Dr. James Richie has left Rapid City to join the Edinger Clinic in Huntington Beach, California.

* * *

Dr. and **Mrs. Andries deBoer** of Lennox, were granted citizenship early in March. Both are natives of Holland.

* * *

Announcement is made of the 48th Session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases, which will be held in Saranac Lake, New York from June 3rd to the 21st. The course provides instruction in the field of chest diseases at a tuition of $100 for a three week session. Inquiries should be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 670, Saranac Lake, New York.

* * *

Dr. H. H. Brauer of Sisseton attended a Clinical Review at the Mayo Clinic on March 18, 19, and 20.

* * *

The Aberdeen District Medical Society met on April 3, at the Mexican Room of the Sherman Hotel. W. T. Sweeney, M.D., pathologist at St. Luke's Hospital, presented an illustrated discussion on "Gross Pathology of Common Lesions of the Female Reproductive Tract."

* * *

The Seventh District Medical Society met on April 2, at the Westward Ho Country Club for a dinner meeting. The program consisted of a demonstration of an Emergency Hospital Unit at the Fairgrounds Armory.

* * *

Kenneth C. Johnston, M.D. of Chicago, who appeared on the annual meeting program at the meeting in Aberdeen, South Dakota, in 1960, passed away at the age of 51. Dr. Johnston was well known to many physicians in South Dakota. His passing is a great loss to his many friends.

* * *

Dr. A. P. Peeke, Volga, S. D., has been re-appointed a member of the Committee on Medicine and Religion of the American Medical Association. The re-appointment of Dr. Peeke was announced by Dr. Percy E. Hopkins of Chicago, Chairman of the AMA's Board of Trustees.

* * *

The Mitchell District Medical Society met March 28th to elect **F. D. Gillis, M.D.,** president. **Dr. Jack Berry** was named vice-president and **Dr. Richard Hockett** was named secretary-treasurer.

* * *

Dr. W. L. Taylor, Aberdeen, has been certified by the American Board of Internal Medicine.

Harold L. Frost, M.D., Rapid City, South Dakota, has been named diplomate by the American Board of Pathology.

* * *

The South Dakota State Medical Assistants Association will hold their 7th Annual Meeting on May 17-18, 1963, at the Corn Palace Motel in Mitchell, South Dakota.

Election of officers will be held.

* * *

Dr. Paul R. Leon of Aberdeen has become a member of the Radiologic Society of North America.

* * *

Dr. Eberhard Heinrichs, Watertown, completed the Board requirements in Pediatrics in March, 1963.

* * *

Dr. Harry J. Bartron became a Fellow in the International College of Surgeons in March.

* * *

The Whetstone Valley District Medical Society met on February 13, at the Legion Hall in Milbank, S. D. **Dr. Warren Jones,** of Sioux Falls spoke on "Changing Trends in Diagnosis and Treatment of Cardiac Diseases." The following officers for 1963 were elected:

President
E. J. Batt, M.D.
Secretary
H. H. Brauer, M.D.

DR. GEIB NAMED TO BASIC SCIENCES

Dr. Wayne Geib, pathologist from Rapid City, South Dakota, has been appointed by Governor Archie Gubbrud to the State Board of Examiners in the Basic Sciences, replacing Dr. John McGreevy of Sioux Falls, who resigned. Dr. Geib's appointment is effective until July 1, 1963. Dr. Geib was one of three recommended by the State Medical Association.

U OF C HEARS DR. PAUL BUNKER

The combined Surgical Staff of the University of Chicago Medical School heard a discussion on "Unusual and Unrecognized Foreign Bodies in the Esophagus and Respiratory Tract — Their Management and Prevention" by **Dr. Paul Bunker** of Aberdeen, on March 12. The same day, he spoke to the residents in Otolaryngology on "Practical Points in Endoscopic Technique." Dr. Bunker is a member of the Council of the American Broncho-Esophagological Association, and Chairman of its National committee on the Prevention of Foreign Body Accidents.

ABERDEEN DISTRICT HEARS McCARTHY

The March meeting of the Aberdeen District Medical Society was held on March 6, in the Mexican Room of the Sherman Hotel. **Dr. Paul McCarthy** of Aberdeen, presented an illustrated discussion on "Carcinoma of the Uterine Cervix." The Woman's Auxiliary of the Aberdeen District met with the physicians for dinner and held a business meeting afterwards.

BLUE SHIELD PLANS MEET IN CHICAGO

The annual business meeting of the National Association of Blue Shield Plans was held in Chicago, on March 31, through April 2. Representing South Dakota as its voting delegate was Dr. Paul Hohm, president of South Dakota Medical Service, Inc., and as alternate voting delegate, John C. Foster, executive director of the Plan. Richard C. Erickson, assistant executive director, was also in attendance at the meetings.

Main discussions at the meetings centered around a marketable national accounts agreement, which would allow the Plans to cooperate together in providing a contract that would be attractive to large national employers, the same as the Federal Employees Program was worked out with the Civil Service Commission.

Another area of interest was a resolution to establish a task force to help states implement Kerr-Mills legislation, utilizing a pre-payment or Blue Shield fiscal agent concept.

One resolution to ask the Federal Government to subsidize Blue Shield Plans in their programs for people over age 65, not necessarily beneficiaries of Kerr-Mills, was beaten down with only one or two dissenting votes.

Don Eagles, executive director of the North Dakota Blue Shield Plan, was named to the Board of Trustees of the National Association for another two year term.

NATIONAL FOUNDATION SPONSORS CONFERENCE ON CONGENITAL MALFORMATIONS

The Second International Conference on Congenital Malformations will be held in New York City, at the Americana Hotel on July 14-19, 1963. The Conference is sponsored by the National Foundation — March of Dimes.

For further information, contact William S. Clark, M.D., Director, Medical Department, The National Foundation, 800 Second Ave., New York 17, New York.

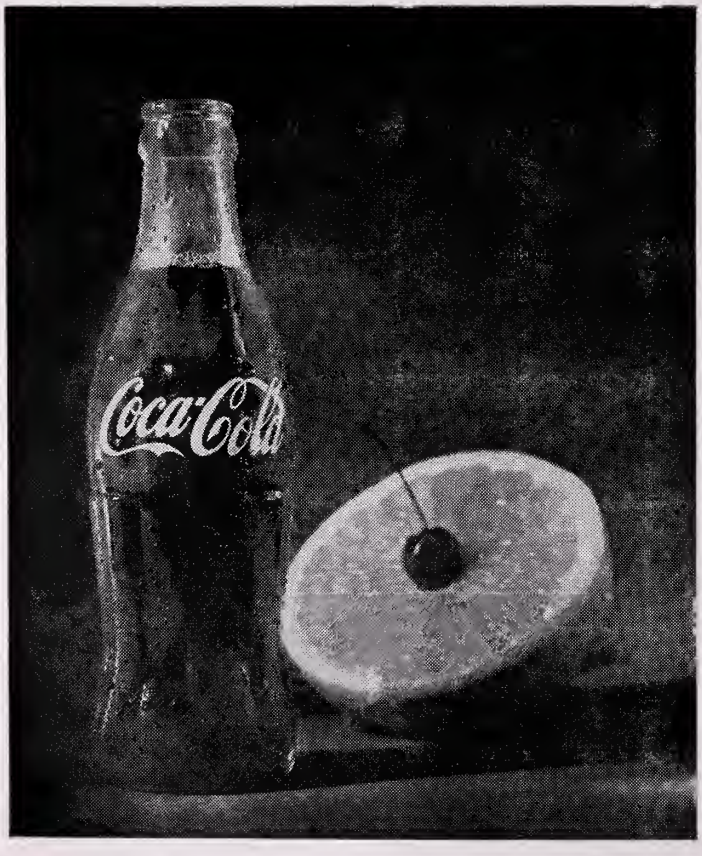
USD RECEIVES AMA-ERF FUNDS

A check for nearly $9,000.-00 of AMA-ERF funds was turned over to the University of South Dakota Medical School by the president of the State Medical Association, **Magni Davidson, M.D.,** during the Medical School's Student AMA dinner dance in Sioux Falls. According to a recommendation made by the Medical Association earlier, the funds will be used to implement faculty salaries.

SPINK NAMED INTERNISTS' HEAD

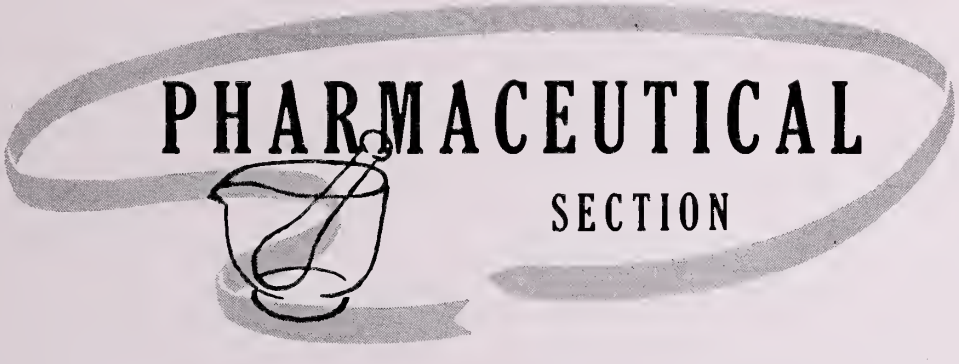
Wesley W. Spink, M.D., Minneapolis, Professor of Medicine at the University of Minnesota Medical School, was named president of the American College of Physicians on April 4th. The meeting was held in Denver and Dr. Spink took over the position held by F. M. Hanger, M.D. of Staunton, Virginia.

Dr. Spink is well known to South Dakota physicians having given numerous scientific papers in this State, including several at State medical meetings.

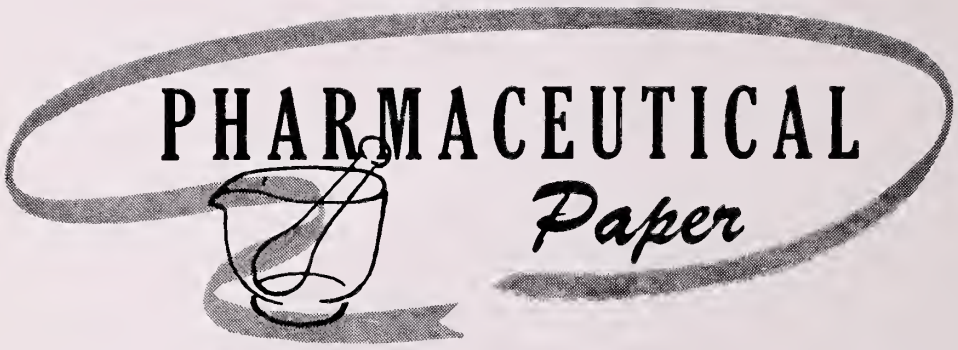


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GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota



IRONIC CONTRAST: US AND USSR DRUG INDUSTRIES[1]

By
Raymond A. Bauer and Mark G. Field

The ironic contrast (or lack of contrast!) represented by the following quotations points up lessons for all American businessmen, whether concerned with the pharmaceutical business or the working of the economy as a whole:

> An official of Czechoslovakia's state health establishment, concerned with the manufacture and sale of drugs, recently asked a European representative of an American drug firm for some material from the hearing held as a result of the Senatorial (Kefauver) investigation of the American pharmaceutical industry. Curious about the interest shown, the American asked if he wanted the entire transcript. "Not so," replied the official. " I don't want the full text, just the rebuttal material used by your American manufacturers. They say our drug prices in Czechoslovakia are too high!"[2]

According to Senator Estes Kefauver, who headed an investigation of the U. S. pharmaceutical industry, "Ethical drug prices are generally unreasonable and excessive. They are unreasonable whether compared to costs, to profits or to prices in foreign countries . . . . Under the big drug companies' brand names, [certain] products are sold to druggists for around 18 cents a tablet and the suggested price to consumers is 30 cents a tablet. Yet the cost of production for these tablets, including tableting, bottling and packaging, is no more than 1.5 cents per tablet. [A] patient will frequently remain for long periods on a dosage of about 100 of these tablets a month. Thus he pays $30 a month for his medicine, for which his druggist paid $18 and which cost around $1.50 to produce."[3]

Speaking before the Supreme Soviet of the U.S.S.R. in February 1957, Maria D. Kovrigina, then Health Minister of the Soviet Union, complained bitterly about the retail prices of drugs in the U.S.S.R., particularly antibiotics. Pointing out that over the previous five years the unit cost of production in the medical industry had been more than halved, she wondered why this did not entail a corresponding decrease in the retail prices of Soviet pharmaceu-

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[1] Reprinted, with permission, from Harvard Business Review, September-October, 1962. Copyright 1962 by the President and Fellows of Harvard College.

[2] Walter A. Munns, president of Smith, Kline & French Laboratories, in a speech before the New York Security Analysts, Inc., January 9, 1962, New York.

[3] Statement of Senator Estes Kefauver, Hearings before the Senate Subcommittee on Antitrust and Monopoly, The Drug Industry Antitrust Act, S.1552, Washington, July 5, 1961, p. 2.

ticals. On the contrary, concluded Madam Kovrigina, "The prices of some highly effective preparations are four, five and even six times the wholesale prices. Reducing retail prices of medicines . . . is a very important step. We have made such a proposal to the U.S.S.R. Council of Ministers and we expect our request to be met."[4]

In support of "The Drug Industry Antitrust Act," Senator Kefauver went on to say, "Prices [must] be brought down, not by governmental fiat, but by the rivalry of competing producers in the market. To make this competition fair as well as effective, certain safeguards and limitations are provided for [in the proposed bill]. These safeguards will also have the corollary effect of improving the quality and reducing the quantity of information distributed to the physician . . . . Unless this measure or something closely resembling it is adopted, the American people, whose patience with price gouging in drugs is wearing thin, will demand that their Government adopt the tougher approach of direct governmental controls."[5]

The Major Complaints

The irony is not just that, as these quotations reveal, the Soviet and the American systems of drug production and distribution have both come under attack from critics at approximately the same time. The major areas of criticism are identical in the two countries — the role of research laboratories, the social costs of promotion, problems of brand differentiation and quality control, and the relationship of the producer to the consumer. But, since the economic systems of the two nations are so different, it is not surprising that the specific charges within this general area of discontent are reversed, like mirror images.

Vice Versa

The major complaint made against the American ethical pharmaceutical industry is that there is too great a disparity between the costs of production and the retail prices of drugs required to maintain the health and life of the nation. The "high price of drugs" is usually attributed to two distinctive causes: (1) allegedly unnecessary duplication of research facilities for competitive commercial reasons, and (2) purportedly excessive promotional costs.

In the Soviet Union and other Eastern Communist countries, a reverse situation is receiving equally bitter criticism. There, the system for promotion of drugs is minimal, and pharmaceutical research is conducted, not by individual drug firms but by government-sponsored "institutes," supposedly without wasteful duplication.

Indeed, in one sense, the Soviet system seems to embody the ideal alternative to the U. S. commercial drug system that some critics cry out for. Why then do the Soviets not find it ideal? Are there lessons that we Americans — whether critics or friends of the pharmaceutical industry — might learn from a comparison of the assets and liabilities of each system? Why doesn't the Soviet experience with "nonprofit" drug production and distribution lead to lowered costs and greater efficiency? Are the arguments for changing the institutional arrangements and practices found in our system economic or political? Let us take a closer look and see.

Underpromoted Drugs?

One major criticism of the American ethical drug industry centers around the high costs of promoting drugs, along with the practice of maintaining brand names and brand lines. Critics of the American pharmaceutical industry see no justification for price differentials to exist between these branded drugs and the unbranded "generic" drugs that are chemically identical in their main ingredients and which, since they usually are not promoted in any substantial way, generally sell for less at the manufacturer's level.

Regarding the expense of promoting branded drugs as especially unwarranted, the more extreme of these critics argue for reducing promotional activity to some minimum system of announcements of new drugs, with the major job of communicating the drug's characteristics and usefulness to be performed by the medical profession or the government, or by both. Brand names, presumably, would be done away with, or become for all practical purposes irrelevant. The assumptions behind these criticisms are more

[4]Izvestia, February 8, 1957, p. 5.
[5]Statement of Kefauver, op. cit., p. 15.

complex than generally recognized, and seem to be based on the following beliefs:

1. A satisfactory noncommercial source of information about drugs can be established without too much difficulty.
2. If information is reasonably available, physicians will take the initiative to see that they keep up to date.
3. The well-informed physician will not be concerned with the reputation of the firm producing the drug, but only with the drug's properties as described in an official pharmacopoeia.
4. Adequate quality can be ensured at reasonable cost by a government inspection system.
5. An ample supply of pharmaceuticals will be produced if reasonable profits are allowed on individual drugs.

The Difference

One way of finding out whether these beliefs have much validity is to see whether they hold true in the "nonprofit" Soviet system, where drugs are underpromoted. Note that although we use the term "nonprofit," it is true that in one sense Soviet manufacturers must operate at a profit; that is, the value of the production must exceed the input in terms of materials, personnel salaries, and so on. Indeed, the high prices Madam Kovrigina complained about may have been due to unreasonable profits in this sense. Profits, on the other hand, do not play the critical role they do in the West, where they determine the life and death of a firm.

Perhaps more relevant here is the fact that the Soviet pharmaceutical system is "noncommercial." As such, it is operated by the government and is characterized by rather extreme centralization and bureaucratization, and also by the existence of rigidities and slowness in action that are so often associated with an advanced bureaucracy.

Having over-all responsibility for the pharmaceutical system of the Soviet Union are two specialized organizations within the U.S.S.R. Health Ministry:

1. The Pharmacological Committee (itself a part of the Department of Specialized Medical Assistance of the Ministry), primarily an advisory and "expert" organization, has the primary duties of recommending new pharmaceutical preparations and of removing from the market pharmaceuticals that have become obsolete. Within that committee there is a commission "on instructions and informational materials," which presumably prepares literature giving knowledge about the existence and the application of new pharmaceuticals.
2. The second organization concerned with pharmaceuticals is also lodged in the Health Ministry and is entitled the Department of Pharmaceuticals and Medical Technology with a Quality Inspectorate. The main functions of this department are (a) to ensure the standardization of drugs produced in the Soviet Union, (b) to edit the Governmental Pharmacopoeia of the U.S.S.R. and to make periodic additions to it, and (c) to examine complaints of nonstandard production.

Neither of these two organizations seems to incorporate a formal, specialized, active, and dynamic system for disseminating information about new drug products to the physicians practicing in the U.S.S.R. that in any way parallels the work done by the American drug industry's detail men (the name given to drug company salesmen who regularly visit physicians for the purpose of familiarizing them with their company's new drug offerings in the hope that the physician will prescribe them when suitable). Rather, the picture appears to be one of general announcements in the medical and sometimes the lay press or other media of mass communications when a new compound or agent is cleared for production. Special information supplied to physicians often amounts to nothing more than simple one-page "flyers." These steps, it is clear, make information minimally available, and presumably, physicians with initiative and interest could keep informed thereby.

No Time

Unfortunately, this assumption about the initiative of the physician and his ability to keep up with new medical products seems to be as unfounded in Soviet society as it is in the United States. Indeed, the belief that people automatically will make use of information or products if these are available is not borne out by the evidence. In the particular case of physicians, it would be closer to the truth to assume that in many instances they are much too busy to give a careful

reading to the little flyers that flutter across their desk or even to peruse the medical literature systematically in search of new drugs. Or, alternately, such minimal sources of information may not make an adequate impact on the physician's mind.

Thus, the expectation that doctors will dutifully note such drug innovations and promptly prescribe them for the next patient to whom they apply seems to be expecting too much under contemporary conditions of medical practice. Rather, it would seem that more active methods are necessary to force-feed this information to physicians. And, to some degree, the Soviet medical literature reveals that Soviet health authorities are well aware of the communication problem and are attempting to take certain steps that will remedy it. Complaints of inadequate information about new products are endemic. Eight such complaints were registered during the first seven months of 1961 in one source, Medical Worker, a semi-weekly house organ of the Ministry of Health. The flavor of these complaints can be gathered from the following fairly typical extracts:

> "Information about new drugs is given irregularly so that practicing physicians do not know about them and are deprived of the possibility of using them. The process of replacing old-fashioned drugs by new and more efficient ones, is too slow."[6]

> "It is necessary to point out that as yet physicians and pharmacists are poorly informed about new drugs. Any information is purely accidental . . . . The pharmacological council has advised the State Publishing House of Medical Literature to publish as soon as possible four publications on new pharmaceutical products."[7]

> "Too much time is wasted in pharmacies on compounding prescriptions, and this is only because the physicians do not know about the pre-compounded drugs. . . . Obviously, only very few general practitioners follow the literature in which the new drugs are described. . . . On the other hand, pharmacy employees do not inform physicians about existing drugs. They do not come to the polyclinic and do not promote the new pharmaceuticals."[8]

[6]Medical Worker, April 4, 1961.
[7]Ibid., June 6, 1961.
[8]Ibid., May 19, 1961.

This picture is an ironic inversion of the situation in the United States. Missing are the complaints about "junk mail" and "pill peddlers." While there may be difficulties associated with an "overpromoted" drug system, the Soviet experience indicates that "underpromotion" produces its own characteristic problems.

Rx for Soviet Drugs

Efforts have been made in the U.S.S.R. to give greater publicity to new pharmaceuticals. For example, polyclinics have been requested to set up special displays of new pharmaceuticals. According to the Soviet press, however, these displays often are nonexistent. Nor are there listings of currently available drugs, presumably because of the intervals between the appearance of new editions of the official pharmacopoeia.

As we have seen, some of the remedies proposed by the Soviets (and to some degree implemented by them) appear to be quite orthodox by our standards: publication of pamphlets, displays or exhibits, listings by the Health Ministry, and so forth. Even more interesting and significant, however, is the fact that representatives from the pharmacies or from pharmaceutical warehouses or subdepots are now being sent to the clinics to inform physicians about what new pharmaceuticals are available and, in turn, to find out their needs and requirements.

A Rose by Any Other Name

These representatives are, doubtless, the functional equivalents of the U. S. drug industry's detail men. And, significantly, Soviet criticism is leveled at those pharmacies that do not use detail men, or do not engage intensively in promotional activity, while praise is heaped on those that do. For instance, a 1960 article in the Medical Worker approvingly describes how a representative from a pharmacy periodically visited physicians and appeared before assemblies of doctors, providing information on new drugs. Such assemblies make it possible, of course, for the representative to reach a wide range of physicians, since they take place periodically at the district polyclinics where physicians in the community, all working under one roof, see their patients. One might well wonder, however, whether such mass presentations adequately can meet the need which is served by the person-to-physician presen-

tations provided by the U. S. detail men.

There is a definite but subtle overtone of "unsocialism" to complaints that representatives of pharmacies are not sufficiently diligent in promoting new drugs. But even more unorthodox is the proposal of vigorous advertising. Historically, advertising has been regarded by Soviet authorities as a socially wasteful device for foisting off on people goods they do not need. Since this attitude has, of late, undergone some modification, the advertising of pharmaceuticals has come to be advocated as a means of keeping doctors informed. For example, articles in both Medical Worker and Pharmaceutical Affairs in 1960 and 1961 complained that new pharmaceuticals do not become immediately available to practicing physicians. Why? Because of "a lack of well-established information about medical novelties." Both articles advocated an information service via press, radio, TV, leaflets, and so forth.

Import for the U. S.

Soviet experience with a functionally inadequate informational service for pharmaceuticals, and the recent Soviet awareness of the role that can be played by various forms of promotion (either detail men or increased advertising activities in the mass media—or both) should not be taken as justification, per se, of any level of expenditure or any one promotional practice. It should alert us, however, to a closer examination of the by-product of promotional activities in the selling of pharmaceuticals.

A distinction between what have been called manifest and latent functions may be useful in this context. The manifest function of promotion, advertising, and detail men — at least in our society — is to sell drugs by persuading doctors to prescribe a certain product by its brand name. But this, as we have seen, is often looked upon with suspicion as a kind of maneuver that eventually increases the prices of pharmaceuticals. Furthermore, such activity has been criticized as being of no social value and should, therefore, be eliminated.

Overlooked is the latent consequence of such promotional activities; i.e., they serve as professional transmission belts for new information from the manufacturer to the consumer (the physician and his patient). That such a latent function is not superfluous is indicated by the inadequacies (in this respect) of the Soviet system in informing the medical profession about pharmaceutical innovations, and by the efforts of Soviet health authorities to create an institutional system to remedy these inadequacies.

In the light of this examination, then, a question arises about the wisdom of a frontal and wholesale assault on current American practices in the pharmaceutical field. One might ask whether the promotional practices of the ethical drug firms are as antisocial in their consequences as some would have us believe. One might even raise the question as to what might be the social "costs" involved in eliminating these practices. While it is true that, in some instances, abuses have taken place, the question is whether the baby should be thrown out with the bath water.

Noncommercial Research

Both in the Soviet Union and in the United States, the second large area of complaint centers around pharmaceutical research. Since Czarist times, scientific research in the Soviet Union has been carried out primarily in research "institutes" separate from universities and industry. (The closest approximation in the United States might be a government organization such as the National Institutes of Health.) Research in pharmacology takes place in these institutes mainly under the aegis of the Academy of Medical Sciences and Ministry of Health of the U.S.S.R. Production, on the other hand, occurs in organizations that now are under the control of regional economic councils called sovnarkhozy. An approximate parallel in the United States would result if research were performed in university and government laboratories, and production handled by private firms.

Bogged Down

We have already seen the charges leveled against the American industry. But what is the Soviet complaint? Essentially, it concerns unnecessary delays in getting valuable results of pharmaceutical research into effective use by doctors and patients owing, first, to problems in communication between institutes of research and production establishments, and, secondly, to bureaucratic delays, sometimes severe, between governmental testing and evaluation of new drugs and ultimate approval for production.

To anyone familiar with a reasonably technical industry, the steps between laboratory research and production are far from trivial. Under the best of circumstances, this requires the close day-to-day collaboration of laboratory, engineering and production personnel, and involves adjustments, redesigning, and rethinking that may go on for months, and perhaps in extreme cases for years, before the laboratory product has been debugged in production.

As a result of the Soviet arrangement, there are difficulties of communication and coordination between institute and factory which constitute a major bottleneck in getting pharmaceuticals into production. To quote a recurrent theme in the Soviet medical press: "It is essential . . . that research and production be brought closer together so that research accomplishments may be put into practice more rapidly." A measure of the seriousness of this problem is the fact that in the first nine months of 1961 this topic was brought up five times in the Soviet monthly journal, Medical Industry.

Inadequate Setup

The picture that emerges is one of an institutional arrangement definitely inadequate to the complexities of converting a laboratory product into something that can be produced economically in volume. Note the tone of the following complaints:

> "The chemico-pharmacological establishments are slow in bringing a number of the new pharmaceuticals into production. Many pharmaceuticals which have been approved for use in general practice are not yet on the market. . . . The planning bodies do not perceive clearly enough the conditions that exist in the factories when pharmaceuticals are produced. . . . Representatives of the factories noted that the technical instructions received from the institutes frequently do not meet present day requirements. Quite often when they are followed they cause great difficulties and large financial losses."[9]

> "We have too few scientific research institutes concerned with the search for new pharmaceuticals. . . . It is a secret from no one that in our country the period from the birth of a new preparation in the laboratory to its introduction into practice is on the average from three to four years. In some cases it is seven years."[10]

It may be, of course, that Soviet critics of their own system are over-reacting to its difficulties. But, to some Soviet authorities, at least, the liabilities of the present institutional arrangement are obvious. If it were matched against the American system, it is conceivable, but certainly not proved, that the Soviet arrangement could produce — on a ruble-for-ruble or man-for-man basis — as many or more laboratory products as could the U. S. industry. But the testimony of the well-informed Soviet sources is that the separation of research from production tends to produce substantial delays in the availability of drugs to physician and patient.

The speed with which the American ethical drug industry can move a drug from research into production offers a sharp contrast to Soviet slowness. Under ordinary circumstances, an American pharmaceutical manufacturer will begin to work on production problems as soon as laboratory and clinical tests suggest the clinical and commercial worth of the drug. The development of production methods and, in fact, the stockpiling of the drug are usually done in anticipation of approval by the Food and Drug Administration. Thus, in most cases, lag between government approval and the availability of the drug is nonexistent. One must again weigh the social costs of the two arrangements.

Bureaucratic Impasse

The separation of drug research from production in the Soviet Union is not the only cause of delay. An additional cause is the elaborate bureaucratic procedure for the screening of new drugs. Here, once more, we find repeated complaints in the medical press. The reasons for delay seem to be several: the complexity of the procedure, the conservatism of the criteria employed, and some overloading of personnel and facilities. Here is a typical complaint in Medical Worker:

> "Already four years have elapsed since biliarin was proposed. This interval is sufficient to study the drug from all sides, to test it clinically and, having established its useful action, to legalize it and place it into the practice of medicine. But this has not

[9]Medical Industry, May 1961, p. 63.

[10]Medical Worker, July 5, 1960, p. 3.

yet been done. The Pharmacological Committee until now has not delivered the drug its 'right to life' and this is why it is not being produced anywhere."[11]

An example such as this is probably extreme. We have seen no estimates of the average time required for the screening of a drug. Yet the lesson involved is clear and straightforward; there is no point in further elaboration or documentation. No responsible person, either in this country or in the Soviet Union, has denied the need for some form of official screening of drugs. But in both countries there are complaints that introduction of drugs is unduly delayed.

Obviously, there are a series of factors to be balanced off against each other: the cost of a more adequately staffed and equipped screening system, the dangers of passing unsafe drugs, the problems raised by delaying the introduction of new drugs, and so on. Any such screening system will always consume some time; therefore, proposals to extend the responsibilities of government screening authorities must be made with realistic consideration of the delays involved and the need for increased facilities and personnel. There are indications that, in the Soviet Union, steps are being taken to decentralize and speed up the screening process.

Poor Quality

Of more interest, in the light of what is known about problems of quality throughout the Soviet economy, is the question of the quality of drugs produced by Soviet production establishments. Unfortunately, our direct knowledge is quite incomplete. However, what we do know fits in so well with the rest of the Soviet scene that we can venture to fill in some gaps from our generalized knowledge.

There are also frequent complaints in the press about the poor quality of Soviet pharmaceuticals. For instance:

"Our industry does not always produce medicaments of good quality. And so it happened, for instance, that from the overall number of pharmaceuticals which were sent this year for evaluation to the Central Pharmacological Research Institute, more than half were rejected, mainly ampules. . . . The rejects were found especially often in the products of the Khabarovsk and Novosibirsk factories, in the Kharkov factory called 'Zdorovie Trudiashchikhsia,' and in the Moscow factory named 'Semashko.' . . . The above examples show that the workers of the chemico-pharmacological industry do not always work conscientiously."[12]

"Every year, there is an increase in the production of various drugs in our country. Many of them are sent for evaluational testing to the Central Pharmacological Research Institute. In the last year, for example, 112 various drugs were sent to us — ampules, tablets and others. And, it is deplorable that 75% of them did not meet the requirements of the official governmental pharmacopoeia and the technical standards. In the first three months of the current year, the Institute received some dozens more of pharmaceuticals and this time again, from the 74 tested, 58 did not meet the requirements."[13]

The fact that there is an endemic problem of quality facing the Soviet drug producers cannot be doubted by anyone familiar with the medical press of that country. The reasons for this problem seem also to be clear. As is generally true in Soviet industry, quality control is not well built into the manufacturing process. The Soviets rely on testing done by an independent inspection system, in this case, the Controlling Analytical Laboratories of the Pharmacological Administration.

Efforts to maintain quality control by policing via an external inspection system have been one of the conspicuous failures of the generally successful Soviet economy. In various ways this failure is being acknowledged throughout the economy.

The first signs of corrective steps which might be taken in the pharmaceutical industry have occurred recently. Last year a writer in the Medical Worker stated:

"At the present time, the testing of the quality of medicaments is carried out, as a rule, in the Controlling Analytical Laboratories of the Pharmacological Administration. This work ought to be done first of all in the factories themselves by their technical control branches. It is really there that the necessary conditions should

[11]Medical Worker, August 16, 1960, p. 3.

[12]Medical Worker, February 24, 1961.

[13]Ibid., July 14, 1961.

be created for the continuous control of the quality of the entire output. . . . The time has come when we are justified in demanding that the medical industry deliver production only of the first quality. For this purpose it is indispensable to organize closer contact between the industry and the network of pharmaceutical specialists. The managers of factories should give detailed accounts at the meetings of pharmaceutical societies. In the immediate future there will take place an all-union scientific convention in which representatives of the chemico-pharmaceutical industry, of research institutes, and pharmaceutical workers will take part. The convention is devoted to the problem of the improvement of the production and control of quality of the medicaments in ampules."[14]

This attempt to get the producing organization to take responsibility for quality has become relatively familiar in recent years in the Soviet Union. Four decades of running a socialist economy have cured Soviet economists and administrators of the tendency to take quality for granted.

Until relatively recently the task of inspection was left in its virtual entirety to the government bureaucracy. There were a number of difficulties with this system:

1. Quality remained substandard.

2. Minimum standards also became maximum standards. Manufacturers had no economic incentives (and Soviet manufacturers do operate according to economic incentives) to produce any quality beyond the minimum required by the established standards.

3. In addition to the fact that quality continued to be unsatisfactory, the system of inspection turned out to be cumbersome, expensive, and, to a large extent, ineffective.

Marketing Innovations

Recently, the Soviet decision has been to pass on this inspection function, at least in part, to the manufacturer and the consumer. Each factory has been required for some time to affix to its products some identifying mark. At present, manufacturers in many areas are being urged to adopt a trademark which really is a somewhat more overt version of the production mark, thus making it still easier for the consumer to identify the factory.

[14]Medical Worker, November 28, 1961.

At the present time, we have no evidence that the Soviet Union is pushing trademarks or brand names in its pharmaceutical industry. To the best of our knowledge, all Soviet factories producing the same type of drug use the same name for it, and often the same type of packaging. While no factories have made a deliberate attempt to publicize their names, it is nonetheless true that the consumer can identify, from a careful reading of the package, which factory or which economic regional council is responsible for its manufacture.

Capitalism Copied

Some recent developments on the Soviet economic scene would lead us to believe that the situation in the pharmaceutical industry may not be essentially different from that in the consumer goods industry where trademarks have been, or are in the process of being, developed. If responsibility for quality control is to be placed prominently on the factory, the logic of the situation would be that the factory would then try to give itself a distinctive identity in order to capitalize on the superior quality of its products.

There are also problems related to selective shortages of particular drugs. Since the mid-1930's, Soviet pharmaceutical manufacturers, like other Soviet enterprises, have been put on an accounting basis. This means that, in contrast to earlier practices in which costs and prices bore little relationship to one another and no detailed accounting of either was kept, enterprises were assigned quotas of goods to produce, realistic prices were assigned to them, a planned "profit" became a criterion of the soundness of management, and bonuses (as well as other incentives) were made available to managers who exceeded the planned production.

With this partial return to capitalistic practices, some products naturally turn out to be more profitable than others. From this arises the perennial Soviet problem of the "product mix." Sanctions are employed (or attempted) to get the required mix of products out of the enterprise. But, in one way or another, factory administrators manage to evade controls on the product mix so as to maximize their profits.

The Soviet press regularly reports complaints of shortages of drugs and medical

supplies. Among these shortages are frequently the most prosaic of items such as glucose, talcum powder, tincture of iodine, bicarbonate of soda, and even saccharin. In fact, in good commercial fashion, Soviet pharmacies often seem to prefer to stock costly medicines which will produce a high profit for a small turnover, as is obviously the case for the antibiotics whose high retail prices so scandalized the former Health Minister.

U. S. Situation

Now that we have seen how the Soviet pharmaceutical system works, let us turn back to the United States and consider the parallel situation.

Perhaps the best starting point is the contention of the brand-name maufacturer that we must not look at the profitability of his individual products. If an investigating committee accuses him of making unduly high profits on a particular item, he counters by answering that these profits make it possible for him to carry some items which are essential to the medical profession but which give him little or no profit, perhaps even a loss.

In terms of over-all strategy it makes sense for the manufacturer to carry such low-profit items because he attempts to promote himself and his line of products across the board. An inverted way of describing this situation is to say that "customer (i.e., doctor) control" compels him to produce a fairly wide range of items, as well as to maintain quality.

The brand-name manufacturer's picture of his situation is certainly validated, at least in part, by the franker statements of the generic drug manufacturers who admit that they limit their efforts to producing generic versions of only those drugs which can be sold profitably. Such manufacturers are quite specific in stating that there are certain drugs which they will not manufacture. Furthermore, they are equally direct in acknowledging the effort and cost that must be undertaken to educate (or, to use the more commercial term, "promote") doctors in the use of a new drug.

It would appear, then, that the economic motivations of American generic drug manufacturers and their role in promotion are surprisingly similar to those we have attributed to the Soviet manufacturers.

This raises a further interesting question relative to deciding to manufacture a costly drug whose demand is quite limited. We have seen that in the American situation, according to the statements of brand-name manufacturers, it "makes sense" to carry a reasonably full line even though certain items of that line will be marketed at a loss. This loss will be recouped with other items that are in wider demand. The logic of competition here appears to force the manufacturers to turn out some items that individually are unprofitable. As long as the situation remains as described, the public benefits in the long run.

Soviet Circumstances

In the U.S.S.R., on the other hand, the issues are drawn in a different kind of array. The logic of the situation in the Soviet economy would impel the medical authorities to act like generic drug manufacturers. Insofar as decisions to produce this or that item are highly centralized, the likelihood is that in many instances drugs that are in restricted demand and which require high capital investments for their production may not be put into production at all. The absence of competition makes it also unlikely that another manufacturer would undertake such a production, so that in the end the drug will not be manufactured at all, and the general assortment of pharmaceuticals from which the physician can choose will be quite limited. For example, there is specific evidence of delay in the introduction of corticosteroids, the "wonder drugs" used in the treatment of arthritis.

It is, therefore, a moot point whether a decision made by a central governmental body with respect to the production of a full line of drugs would be more favorable to the public welfare than a decision made by a pharmaceutical firm competing on a market and desirous of impressing its brand name on the medical profession. Here, again, it seems that the manifest function of promoting a brand name has the latent effect of encouraging the production of certain unprofitable items. An analysis of the Soviet pharmaceutical situation shows that we cannot take for granted that "wise and rational" decisions are to be "naturally" expected from a central governmental or quasi-governmental body, or even that such decisions per se will lead to the provision of certain items for the population.

(Continued on Page 50)



CONVENTION TIME IS ALMOST HERE

In a few short weeks, your State Association will meet for its seventy-seventh annual convention. The dates are June 23-25; the place is the Holiday Inn in Pierre. For some time now the local convention committee has been hard at work preparing for your presence and we anticipate that the program and arrangements will be among the finest.

It is hardly necessary to say that the last few years have been difficult ones for pharmacy. We are all aware of the unfavorable publicity that the profession has received through Federal investigations, litigations, adverse judicial decisions, stemming from the cries of high drug prices, price fixing and monopoly. In South Dakota, the last legislative session clearly pointed out some of the problems we face locally.

The need to combat this unfavorable picture of our profession is readily apparent and requires both an individual effort on the part of pharmacists everywhere and also the collective effort afforded by professional organizations. But organizations are only as effective as the support they receive from their memberships. Your State Association can be an effective force in this endeavor if you give it your support. One way in which you can help is to attend its annual meetings, contribute in the deliberations and assist in making decisions. Your Association needs your support if it is to effectively serve you.

It is urgent that you, as a South Dakota pharmacist, attend the forthcoming convention in Pierre. In the words of your president, L. B. Urton, "You must help create 'The New Image of Pharmacy.'"

THE FEDERAL GOVERNMENT — SOLE EMPLOYER?

There is more and more government interference in the conduct of one's private affairs; more and more tendency to want to rely on the government instead of doing it oneself; more and more whittling away at the private enterprise system; more and more feeling that business is irresponsible and the professional naive. The government's civilian payroll hit a record high of $14 billion in the last fiscal year, and the first month of the new fiscal year has shown an increase of 14,-530 employees over the preceding month, for a total of two and a half million federal employees on the payroll. Thirty of the states have more federal employees than state employees. Maurice Stans, former Director of the Budget, has reported that every worker in the country will be employed by the Federal Government by the year 2058 if the growth rate of Federal Employment of the last 30 years continues into the future. — Austin Smith, M.D., President, Pharmaceutical Manufacturers Association, to National Association of Chain Drugstores, Oct. 25, 1962.

PRESIDENT'S PAGE



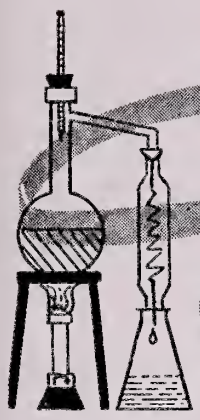
May — under the sign of Taurus — sign of the Bull. So we shall throw a bit of same.

Convention time looms in the near future and there will be many things of importance to decide. It is your Association and your convention; you are a member and you help pay the bills. If you will take one, two, or three days to attend the convention, voice your opinions, and help reorganize where there is weakness, we shall have a strong and respected organization. You must help create "the New Image of Pharmacy."

Truth in labeling food and drug products can go too far. Imagine Omar Khayyam wooing his girl friend and panting romantically, "A loaf of bread, calcium propionate added to retard spoilage; a jug of wine, artificially colored; and Thou."

See you at the State Convention in Pierre, June 23, 24, and 25. For information, contact Red Zarecky, local Convention Chairman.

L. B. Urton
President



Advances In Drug Research

REPORT ON CURRENT STATUS OF LAETRILE

Because of wide-spread readership of **THE AMERICAN WEEKLY,** it is felt that the following may be of value to physicians in answering queries on the drug.

The American Weekly, a nationally distributed Sunday newspaper supplement, published a two-part story on March 3, and on March 10, concerning a drug for treating cancer known as "Laetrile." According to its promoters, Laetrile is compounded from apricot kernels in a laboratory reportedly owned by Dr. E. T. Krebs, M.D. of San Francisco, California. His son, Ernst T. Krebs, Jr., is the primary distributor of Laetrile which he has sold to various firms, including Hale Laboratories, Inc., Los Angeles, the Spicer Gerhard Co., Sunland, California, Yaryon Laboratories, Inc., San Francisco, and International Biozymes Ltd., Montreal, Canada. Several of these firms, in turn, have engaged in commercial distribution of Laetrile. As an example the Hale Laboratories' price list in use during November 1960 listed Laetrile for sale at $10.00 a vial or 6 vials for $58.00 for "investigational use."

Three court actions have been taken to date involving Laetrile. All three were based on the requirement of the law that a new drug may not be distributed commercially unless it has been established to be safe and effective. Investigation by FDA inspectors disclosed that whereas Laetrile was represented as a drug for scientific research, it was actually being distributed commercially for the treatment of cancer.

1. In the first of these cases, a seizure of 57 vials of Laetrile in possession of Harry R. Taylor, D.O., Dallas, Texas, was made Dec. 28, 1960. Dr. Taylor became the operator of the former Hoxsey Cancer Clinic in Dallas after court proceedings had forced Harry M. Hoxsey to get out of the "cancer cure" business. Dr. Taylor was enjoined from dispensing the Hoxsey nostrums on Sept. 16, 1960. In the seizure action FDA charged that Laetrile was a new drug for which an effective new drug application was not on file with the agency as required by law. The drug was shipped by Hale Laboratories, Los Angeles, to Dr. Taylor with labeling restricting it to investigational purposes, but it was not being so used and therefore was in violation of the law. The seizure was not contested.

2. A criminal prosecution, filed in the Federal District Court at Los Angeles, charged Roy W. DeWelles, D.C., Charles Lyle Hawk, M.D., and Willoughby W. Sherwood, M.D., with the shipment of Laetrile which bore the label of Hale Laboratories, Los Angeles, to a lay person in Idaho. The information charged that Laetrile was a new drug labelled for investigational use and was not shipped to "an expert qualified by scientific training and experience to investigate the safety of

said drug." After the filing of the criminal information, Dr. Hawk and Dr. Sherwood, both past 80 years of age, entered into a comprehensive consent decree of injunction which, among other things, prohibits their use of Laetrile. The criminal charges against these two were then dismissed. DeWelles failed to appear for arraignment on Jan. 28, 1963 and a bench warrant for his arrest was issued by the court and is still outstanding.

3. In a criminal prosecution Ernst T. Krebs, Jr., and the John Beard Memorial Foundation, sponsors of Laetrile, were charged with shipping another new drug which had not been cleared as safe under the law. This product was an alleged "vitamin B_{15}," also known as "pangamic acid," claimed to be effective as a heart stimulant and for improving the performance of race horses. The prosecution was filed November 16, 1961 in the Federal court at San Francisco. The court papers identified the Foundation as an "association" between Krebs and his father, Ernst T. Krebs, Sr., M.D. Both Krebs, Jr. and the Foundation pleaded guilty to five counts of violating the new drug provisions of the law and a total fine of $3,755 was levied. Imposition of a jail sentence for Krebs, Jr. was suspended, and he was placed on probation for three years. As a condition of his probation Krebs was prohibited from making interstate shipments of any new drugs — **including Laetrile** — without getting an effective new drug application from FDA.

The Court also ordered Krebs, Jr., and the Foundation not to manufacture any drug until a drug license is obtained from the State of California. A supply of Laetrile that was already manufactured was later permitted by the Court to be sent to the McNaughton Foundation, Montreal, Canada and to a few other physicians who are allegedly using it for investigational purposes.

Laetrile may not legally be manufactured or distributed in the United States, or imported from Canada, until the requirements of the San Francisco court's probation order and the new drug provisions of the Federal Food, Drug and Cosmetic Act have been met. A new drug application filed by Krebs has recently been reviewed by the FDA and Krebs was notified that the application was found to be incomplete because the data submitted was inconclusive and insufficient to demonstrate either efficacy or safety.

The Food and Drug Administration has seen no competent, scientific evidence that Laetrile is effective for the treatment of cancer.

Prepared by the Food and Drug Administration

(Continued from Page 46)

CONCLUSION

Certainly a parable of this length ought to have a moral. In this case, the moral is a simple one — that is, we must be careful about quavering before criticism of our established way of doing things, and about assuming blindly that if our way has some drawbacks, then it is bad, and that a completely opposite method is all good.

We have taken the U. S. pharmaceutical industry as our example, since it has come under such piercing criticism, and compared it with the Soviet system of drug production and distribution. Here are our conclusions:

1. Vigorous promotion of drugs is not necessarily socially undesirable. In the Soviet Union where drugs are even today only mildly promoted, there are substantial lags in the introduction of new drugs and delays in the dissemination of information about those drugs which have been made available.

2. Brand naming of drugs, in itself, is also not undesirable. By brand naming, the responsibility for quality control is placed with the manufacturer, and the customer is enabled to exert pressure on the manufacturer of inferior products. In the U.S.S.R., where quality control is enmeshed in government bureaus separate from the factory, quality consequently suffers.

3. Customer preference, which branding allows, serves in the United States to stimulate brand manufacturers into carrying reasonably full lines, even if some are sold at a loss. In the Soviet Union, factory managers apparently protect their budget by avoiding highly unprofitable items, much as generic drug manufacturers do in the United States.

4. Finally, if research is separated from production, as in the Soviet system, the process of getting laboratory items into production and out to the consumer is drastically slowed.

It is our hope that this exaggerated parable will drive home the point that while our system has faults, the way to correct these faults is to examine carefully the possible drawbacks of those alternatives that seem so easy and obvious, and only to adopt what survives that test.



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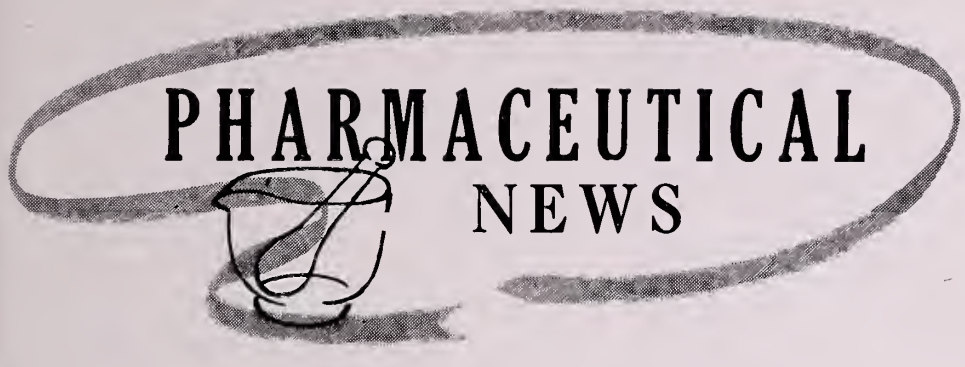
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STATE COLLEGE RECEIVES FEDERAL GRANT

A grant of $50,326 to South Dakota State College from the Public Health Service Health Research Construction program of the U. S. Department of Health, Education and Welfare has been announced by President H. M. Briggs of State.

"Construction of Shepard Hall, new science building, made it possible to utilize this grant program," said Dr. Briggs.

The Public Health Service Health Research Construction program awards funds to colleges and universities, non-profit hospitals and other research institutions to build and equip research facilities, and grants are awarded following approval by the U. S. Surgeon General.

Floyd J. LeBlanc, dean of the Division of Pharmacy at State, and H. S. Bailey, professor of pharmaceutical chemistry, said the $50,326 grant will finance pharmaceutical chemistry laboratories and equipment in the new Shepard Hall.

Construction of the new science building at State has already started. Kuipers Construction Company, Mitchell, has the general contract for the structure. Appropriated funds for the project run to $1 million.

Bailey explained the $50,326 grant will go entirely for facilities in health-related research in the new Shepard Hall. Among these new facilities are a dental-pharmacy research laboratory (original research in this area started at State with the cooperation of the South Dakota Dental Association and the South Dakota Pharmaceutical Association), a drug synthesis lab, a laboratory housing analytical instruments, a lab group devoted to radioactive research, a spectro-chemistry lab for infrared and ultraviolet analysis of medicinal preparations, a chromatography lab and a graduate research lab.

Construction is expected to be completed on Shepard Hall in about a year and a half, and it is hoped the new structure can be ready for use in the fall of 1964. The building is being erected in an area formerly occupied by Central and Old North and will be connected with the present chemistry building. Funds for construction were provided by a $1 million appropriation by the 1961 Legislature.

PRELIMINARY CONVENTION PLANS ANNOUNCED

Preliminary plans for the seventy-seventh annual convention of the South Dakota Pharmaceutical Association to be held in Pierre June 23-25 have been announced by Albert Zarecky, general chairman.

Registration will start at 11:00 a.m. on Sunday, June 23rd, at the Holiday Inn Motel. Sunday afternoon will be devoted to a variety of recreational activities; golf, bowling, fishing and boating will be offered. The Allied Drug Traveler's annual party will be held Sunday evening at the Pierre Country Club. This will be a strictly informal, western style get-together.

Business sessions will begin Monday morning at the Community Room of the City Hall and the Annual Association Banquet will be held Monday evening. Mr. Sigurd Anderson, Washing-

ton, D. C., will be the featured speaker. Final business session will be Tuesday morning, with the convention closing at noon.

Chairman Zarecky assures conventioners that there will be plenty of time during the convention to transact necessary business and, in addition, a fine program of recreation and entertainment will be offered. All South Dakota pharmacists are invited to attend with the assurance that their stay will be both profitable and enjoyable.

STAFF CHANGES ANNOUNCED AT STATE COLLEGE

Announcement has been made of the appointment of two new staff members to the Division of Pharmacy, South Dakota State College.

Named were **Robert H. Knott,** associate professor of pharmacy and **Lola R. Schuman,** dental-pharmacy research technician.

Knott, a native of New York state, holds a Ph.D. degree from Oregon State University and is presently employed by that institution. He is a member of numerous professional societies and has had a varied teaching experience. He will assume full-time teaching duties at State College in the Department of Pharmacy, effective September 1.

Schuman, a native of Stratford, will receive her B.S. degree in pharmacy from State College at the June commencement exercises. She will be employed in a full-time research capacity on a dental-pharmacy research project.

FDA COMMISSIONER RECEIVES HONORARY APhA MEMBERSHIP

The American Pharmaceutical Association bestowed honorary membership upon **George P. Larrick,** Commissioner of Food and Drugs, U. S. Department of Health, Education and Welfare, at the Association's 110th annual meeting May 12-17 in Bal Harbour, Florida.

Commissioner Larrick, in receiving the honor, joins nine other living honorary APhA members, including Sir Hugh Linstead, a member of British Parliament and President of International Pharmaceutical Federation (FIP); and Senator Hubert H. Humphrey, Assistant Majority Leader of the U. S. Senate. Both men received the honorary memberships at the 1962 annual meeting.

PRICES OF Rx DRUGS SHOW DECLINE IN 1962

Wholesale prices of prescription drugs in 1962 declined over-all for the fourth straight year, the Firestone Index reveals.

The Index, which measures manufacturers' wholesale prices to pharmacies and hospitals, is constructed annually under the supervision of Dr. John M. Firestone, professor of economics at City College of New York and consultant to industrial and governmental groups.

Dr. Firestone disclosed the 1962 fall in the drug price index in a talk before a Morris County (New Jersey) Pharmaceutical Society meeting recently.

He said the new decline brought the Index to 87.1, 12.9 per cent below the base number of 100.0 for 1949. Thus it continues to reflect a long-term downward trend in wholesale prices of drugs prescribed by physicians, he added.

In contrast, prices of other commodities have moved up sharply during the same period, Dr. Firestone said. He pointed out that the Bureau of Labor Statistics' Wholesale Price Index for all commodities except farm and food has risen 28 per cent since 1949 and the Bureau's Consumer Price Index has increased 29 per cent during the same period.

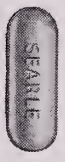
Dr. Firestone said the drug price index has declined in ten of the years since 1949 and has shown an increase in only three. The Index is now at the lowest level for the entire period, he added.

The 1962 fall was again largely influenced by price reductions in antibiotics that occurred in 1961, Dr. Firestone said, adding that this was the second successive year in which antibiotic prices had declined substantially. Vitamins, hormones, and dermatological products showed less spectacular declines.

The wholesale drug price index was first prepared under Dr. Firestone's supervision in 1960, covering the period 1949 to 1959, and has been updated for each succeeding year.

The Index is constructed according to accepted procedures similar to those used by the Bureau of Labor Statistics, according to Dr. Firestone. Leading products in 16 therapeutic classifications and an "all other" class are included, and the components are weighted according to the extent of consumer usage, he said.

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Pro-Banthīne P.A. provides the full anticholinergic benefit of Pro-Banthīne® plus the greater convenience and more consistent therapeutic effect of a long-acting dosage form.

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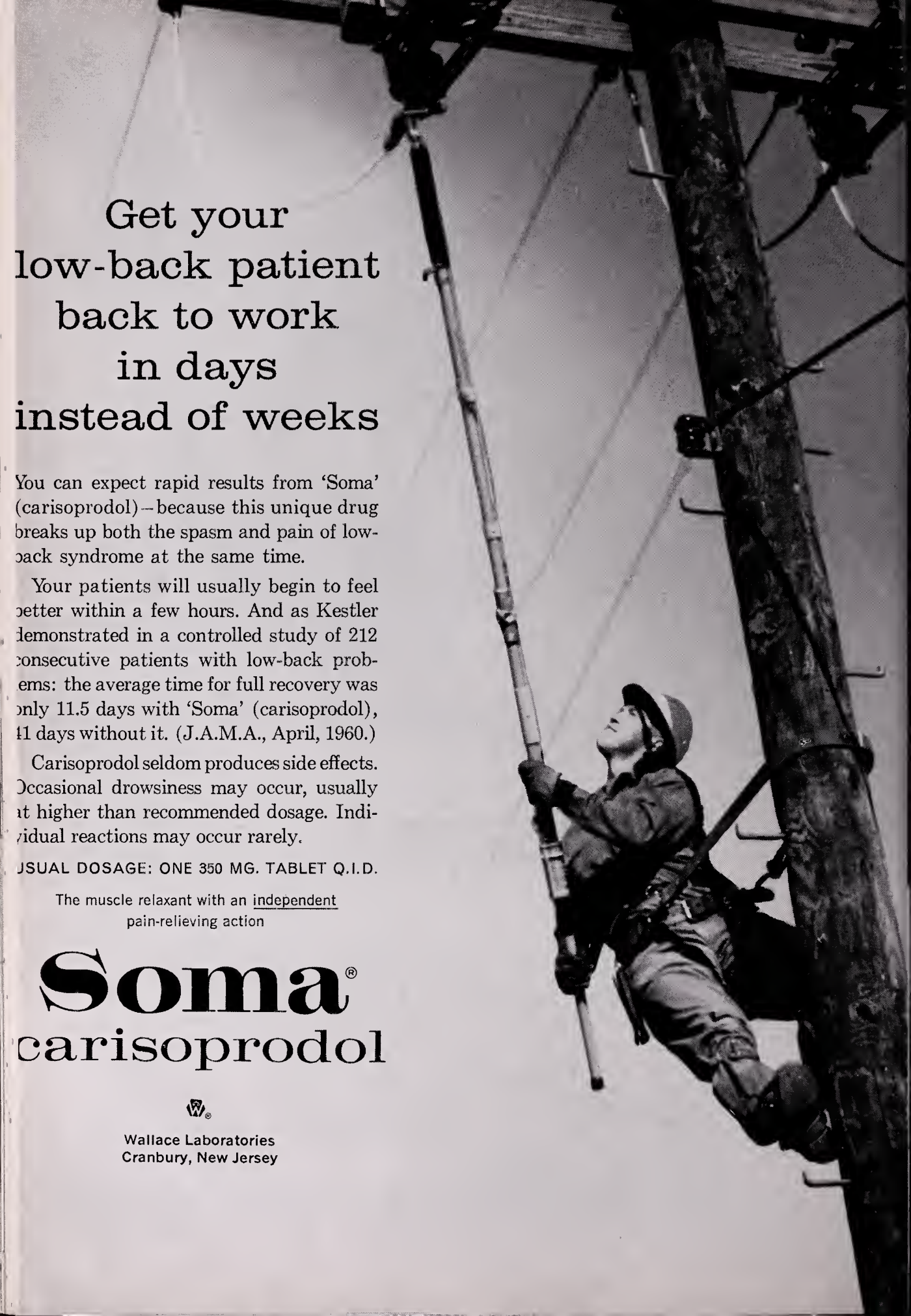
Suggested Adult Dosage:
One tablet at bedtime and one in the morning, supplemented, if necessary, by additional tablets of Pro-Banthīne P.A. or standard Pro-Banthīne to meet individual requirements.

Pro-Banthīne P.A.
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Contraindications:
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Possible Side Actions:
Xerostomia, mydriasis and, occasionally, hesitancy in urination. Theoretically, a curare-like action may occur.

1. Asher, L. M.: The Choice of Anticholinergic Drugs in the Treatment of Functional Digestive Diseases, Amer. J. Dig. Dis. 4:260-275 (April) 1959.



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The muscle relaxant with an independent pain-relieving action

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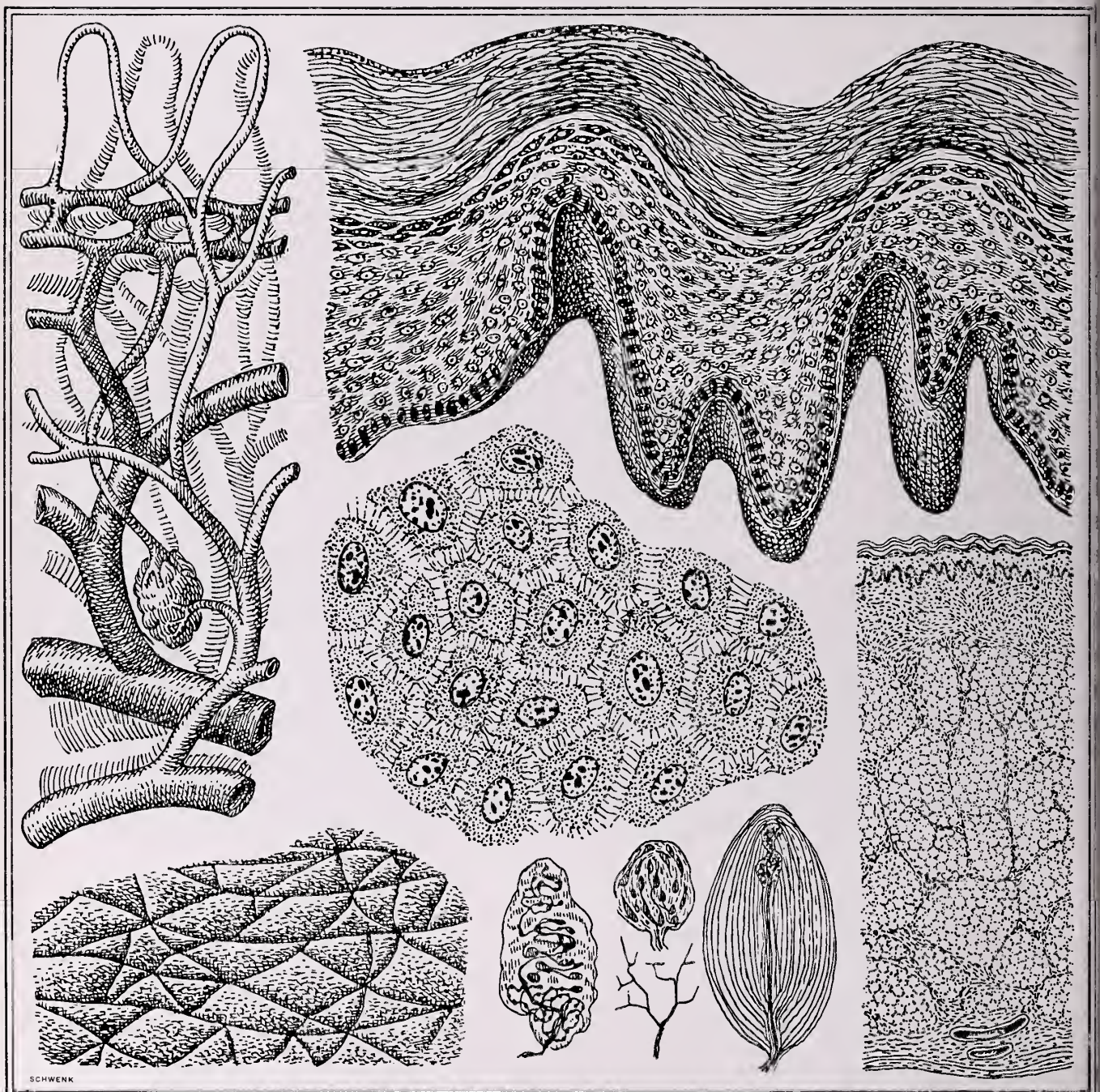
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PRECAUTIONS: ARISTOCORT Triamcinolone should be used with extreme caution in viral infection, particularly herpes simplex and chicken pox, in tubercular or fungal infection, in active peptic ulcer, acute glomerular nephritis or myasthenia gravis.

FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup — 2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

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Hope now, where there was no hope. Drugs which help now, where there were no known drugs which helped—even five years ago. Independent drug research is continuing in this vital area. But, should it be discontinued because the cost must somehow be reflected in the ultimate price of the new drug—if it is to be discovered? Or should the sign read, as it has throughout time in overcrowded mental institutions: "NO VACANCIES."

*U.S. Department of Health, Education and Welfare, Public Health Service Publication No. 813.

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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (4) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (5) Feldman, L. H.: North Carolina M. J. *23*:248 (June) 1962.

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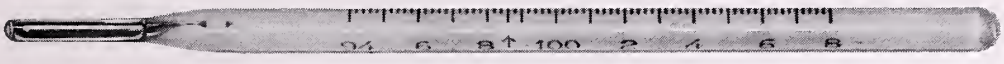
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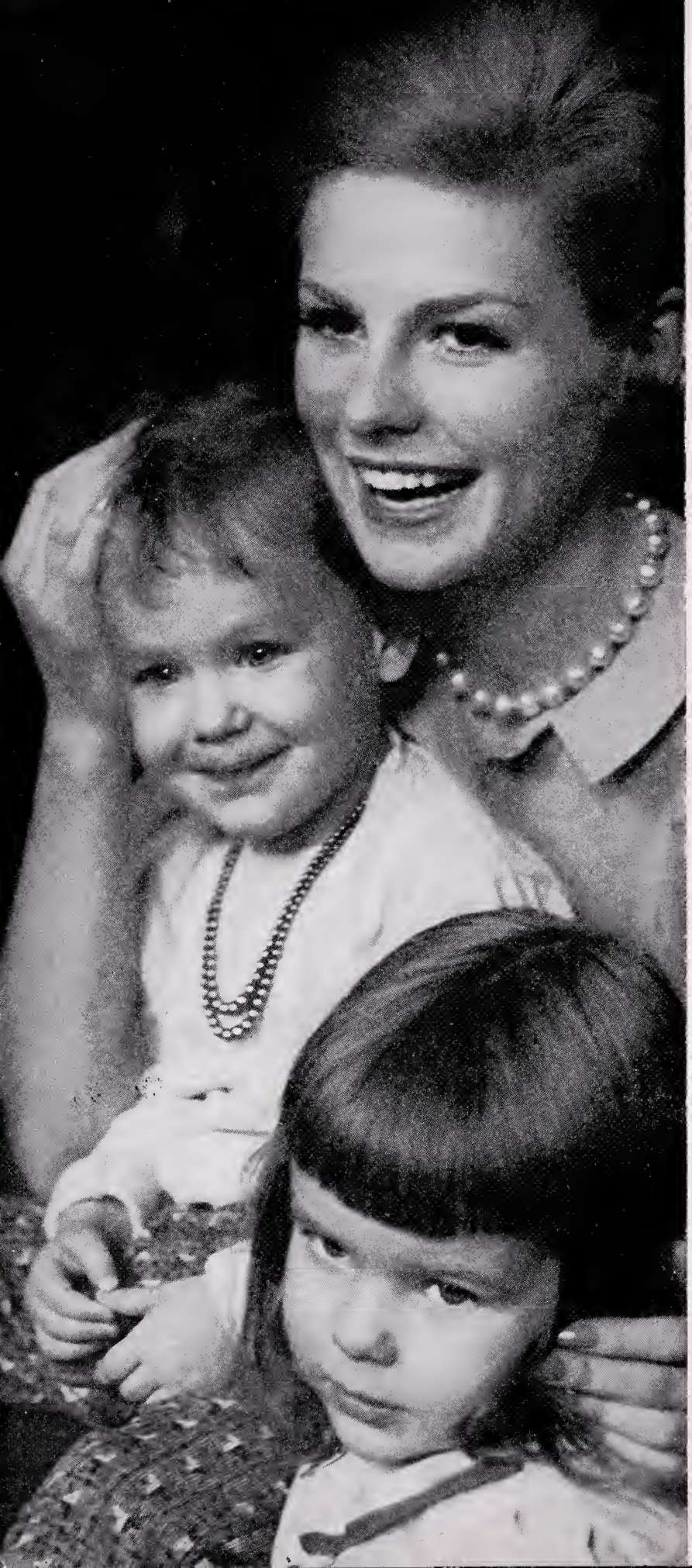
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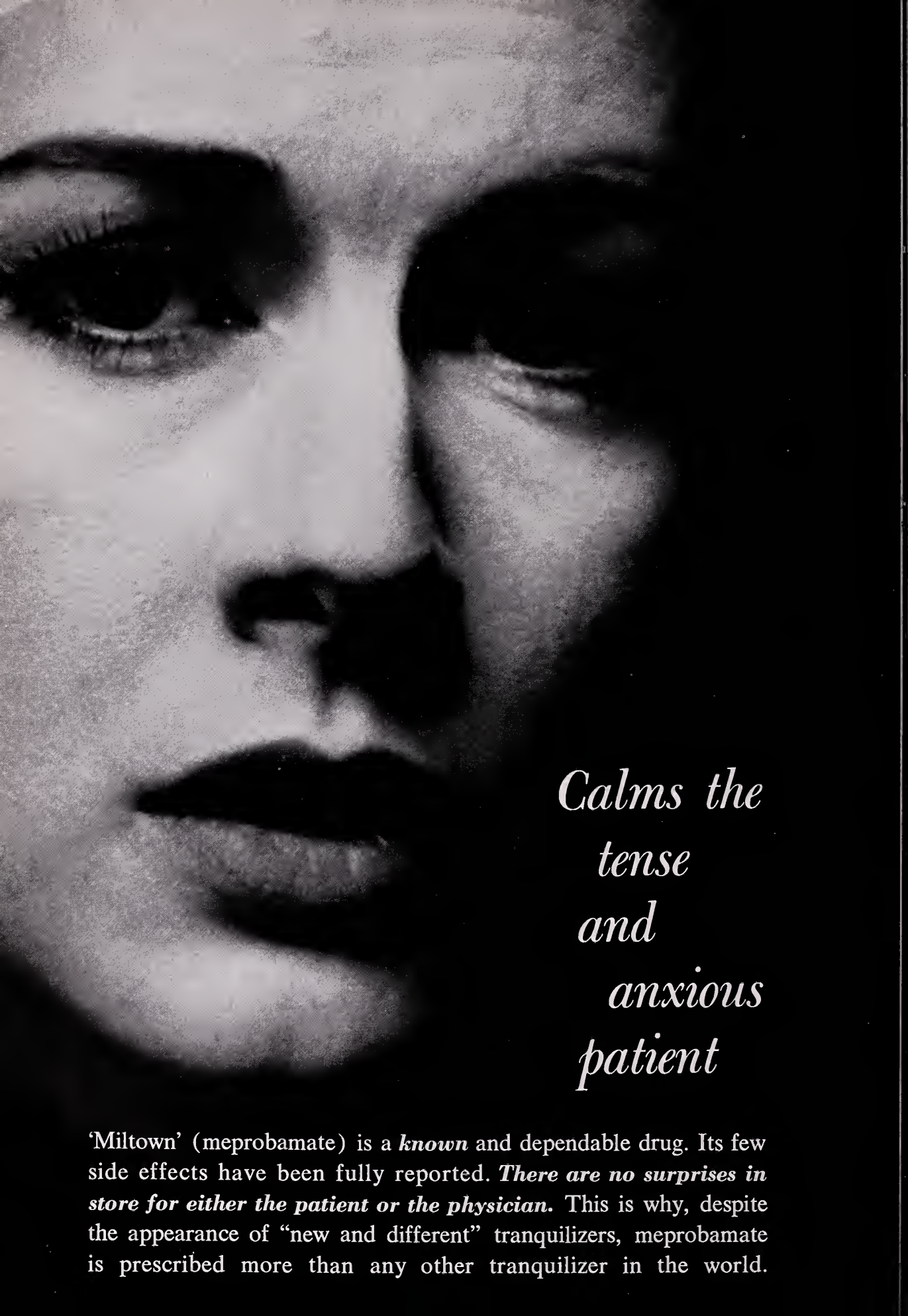
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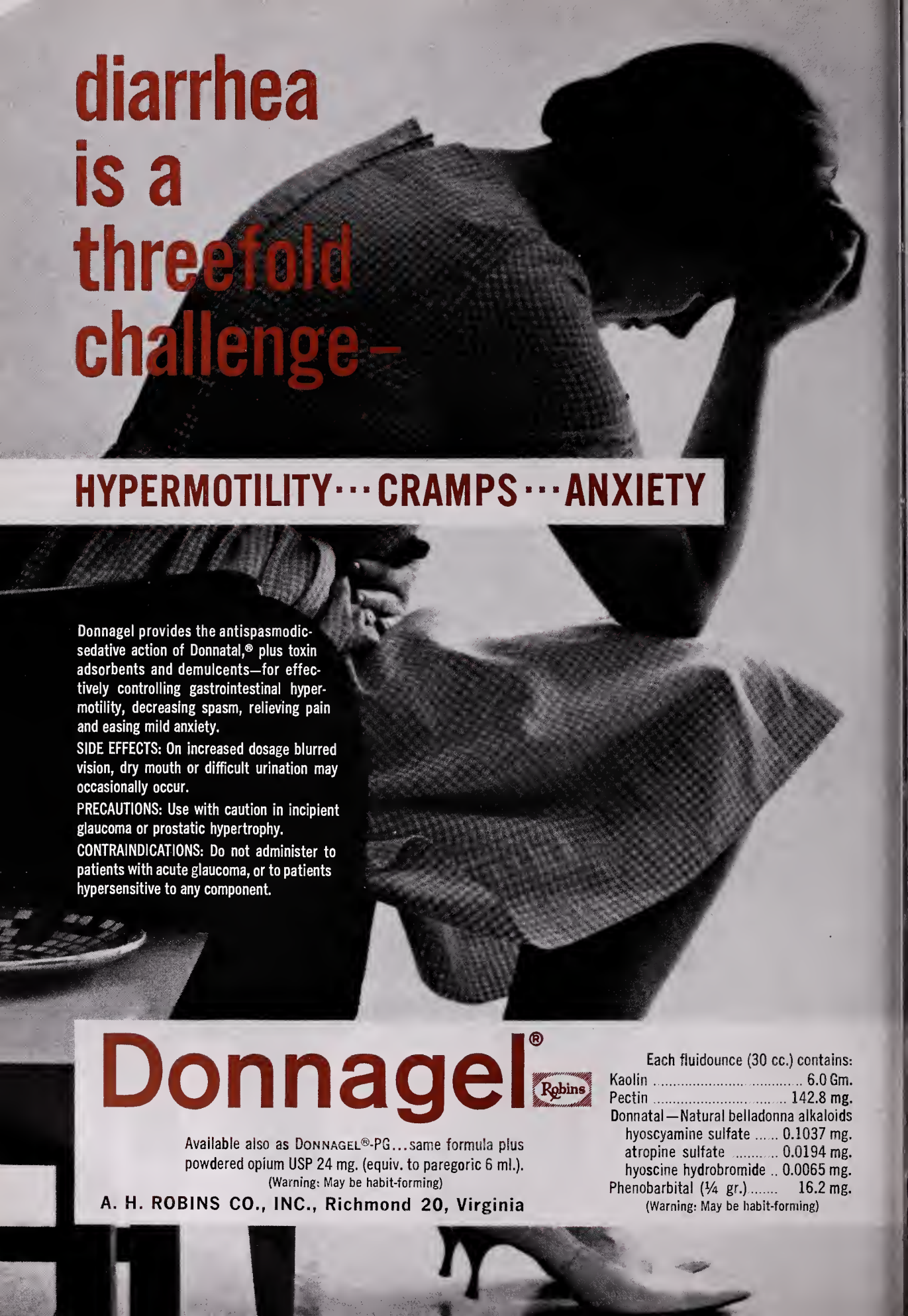
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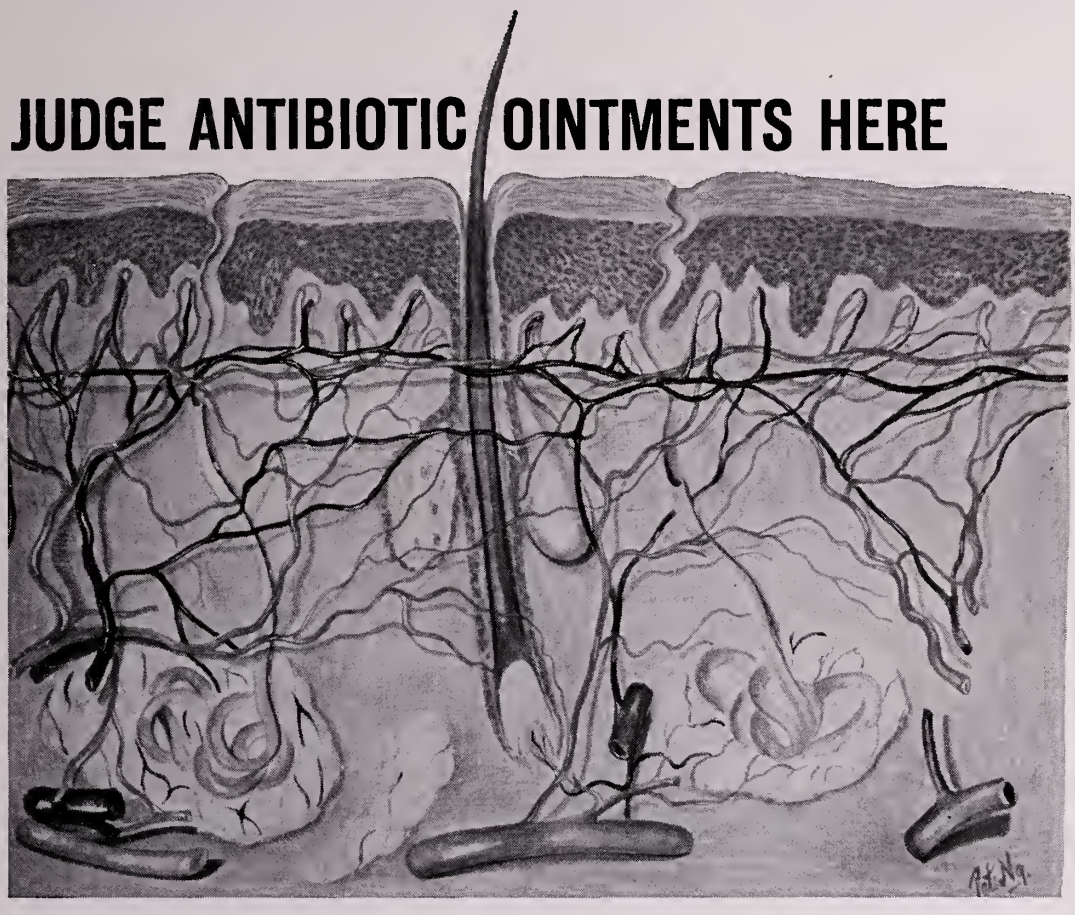


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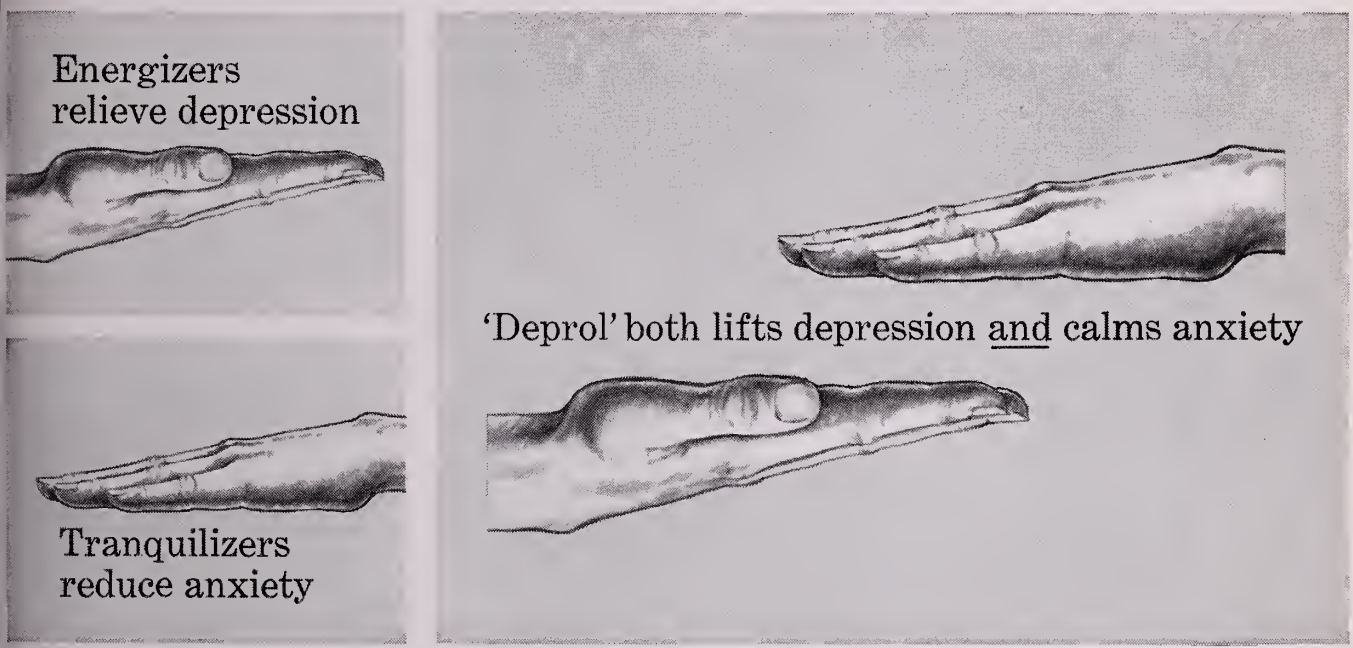
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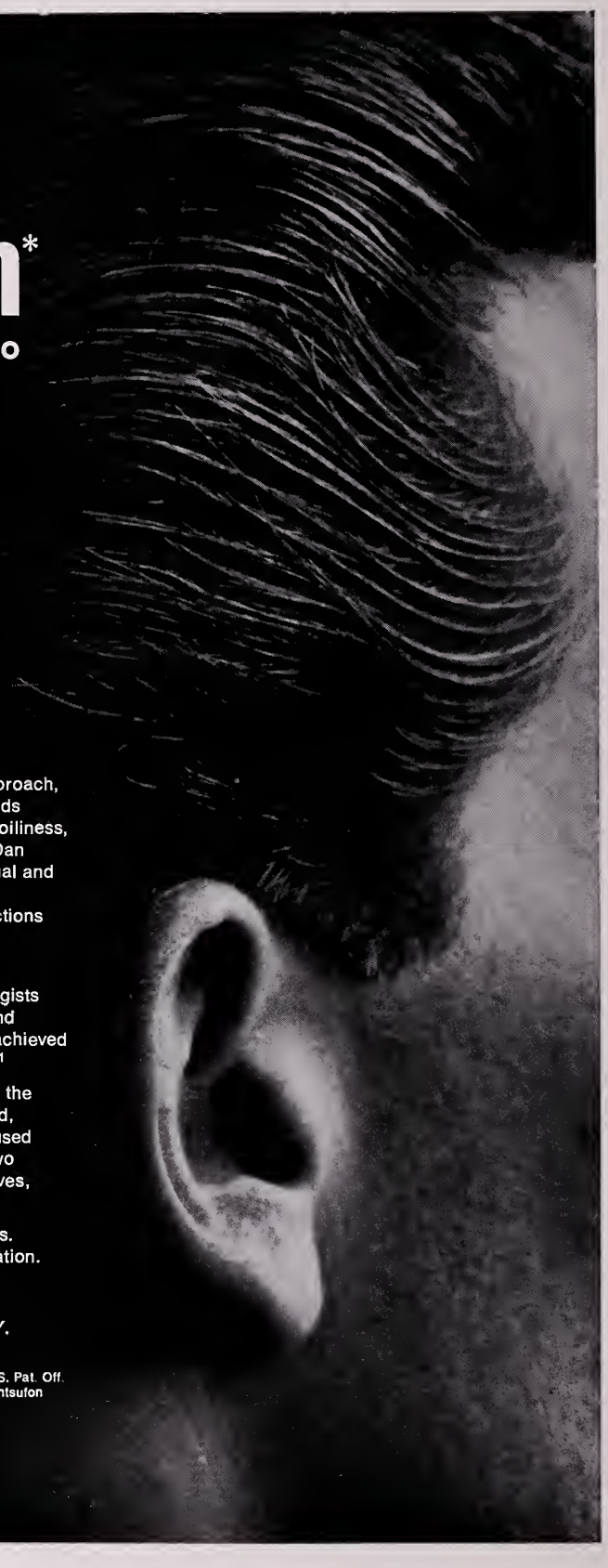
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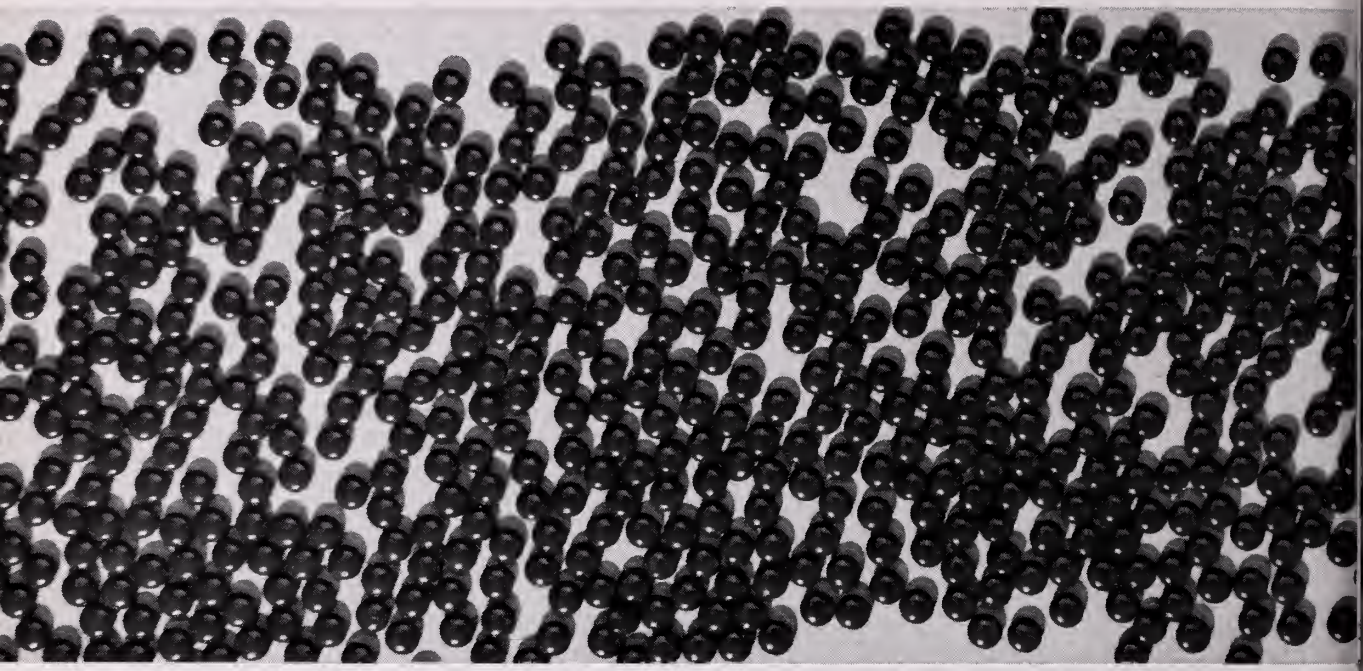
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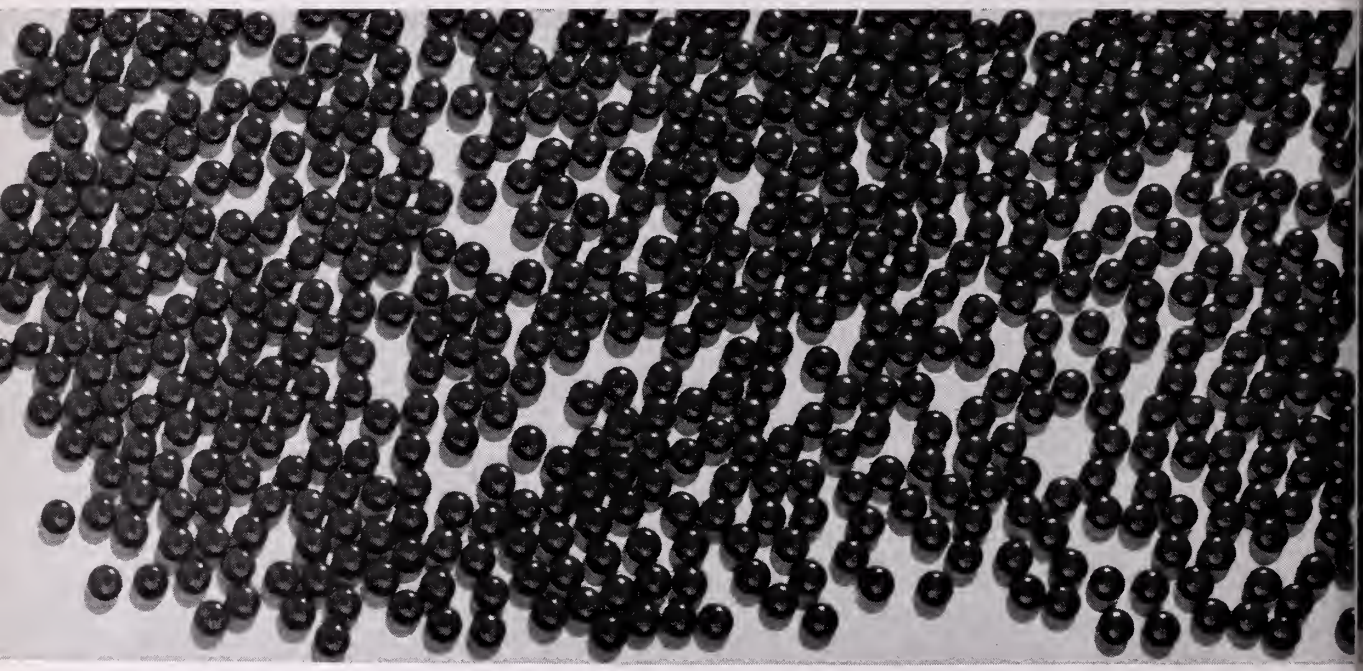
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Scientific PAPER

Term Pregnancy After Ovarian Ablation Prior To The Second Month Of Gestation

C. W. Anderson, M.D.
C. A. Stern, M.D.

From the Department of
Obstetrics and Gynecology
Sioux Valley Hospital
Sioux Falls, South Dakota

The clinical evidence that most pregnancies survive after total ovarian ablation, prior to the 60th day of gestation, is less conclusive than that in pregnancies where surgery occurs subsequent to this time. This, in part, is due to the small number of cases which have been reported in the literature. Of the 50 or 60 cases of bilateral oophorectomy done in early pregnancy, which have been published, surgery occurred in about 30% prior to the 60th gestational day.

We were able to collect some 16 case studies which were restricted to this interval, and report one of our own. A summary of these cases subsequent to 1943 appears in Chart I. The shortest interval between surgery and conception occurred in a case cited by Oettle. This patient had a bilateral oophorectomy for dermoid cysts at approximately the 14th day of conception, and went to term. For the interested reader, a good review of the literature, with case reports, may be found in the papers of Andrews et al, Hall, and Ottolenghi-Prete.

CASE REPORT

M. S., a white 30 year old gravida 2002, para 2, of northern European ancestry was seen by C. W. A. for routine pre-partum care on June 24, 1959. The LMP was May 23, 1959. The patient was Rh negative, and the physical examination and routine laboratory reports were reported as essentially normal.

CHART I

No.	Author	Year	Surgery	Therapy	Day of Gestation*	Outcome
1.	Ayes - Kearns	1945	Lt. twisted simple cyst. Rt. tube and ovary excised 5 years previously.	None	44	Premature deliver at 5 months.
2.	Bonn	1947	Endometrial cysts.	None	50	Term
3.	Falk - Bunkin	1947	Rt. serous cystadenoma left papillary cystadenoma.	5 mg. Progesterone each day.	23	Term
4.	Oettle	1952	Bilateral dermoid cystectomy.	35 mg. Progesterone (total dose)	56	Term
5.	Sheldon	1953	Bilateral dermoid cystectomy.	Progesterone 20 mg. a day.	58	Term
6.	Loza	1954	Pelvic inflammatory disease.	Dilethylstibesterol 10 mg. a day.	56	Term
7.	Ottolenghi - Prete	1960	Bilateral dermoid cystectomy.	Progesterone 10-20 mg. a day	55	Term

*These figures have been calculated from the L.M.P. to show gestational age from conception to surgery.

Past History

The patient had term deliveries in 1951 and 1953. The first labor lasted about 12 hours before it was terminated with a mid-forceps rotation of an occiput posterior; the second delivery was spontaneous with a two-hour labor. The weights of the infants were 7 lbs. 15 oz., and 8 lb. 2 oz. The patient had a history of a duodenal ulcer, with intensive treatment, including transfusion, over the past several years. In 1955 the patient was admitted for a laparotomy for a pelvic mass, and the left ovary and tube were excised. The report of the pathologist (Dr. C. Mitchell, Sioux Valley Hospital) was a pseudomucinous cystadenoma, measuring 6 x 8 cm. and weighing 64 grams.

Hospital Admissions

On July 18, 1959, at about the second month of her pregnancy, the patient became acutely ill with lower abdominal pain of sudden onset. A palpable mass in the left lower quadrant was present. At laparotomy a large left ovarian cyst with a twisted pedicle was excised together with the left tube. The report of the pathologist was an infarcted ovary with a simple cyst of the ovary, measuring 7 x 8 cm., and weighing 165 grams. The uterus at laparotomy was soft and enlarged to a degree compatible with the patient's LMP. The post-operative course was uneventful; the patient was given 10 mg. Norlutin each day. The remaining pre-partum course was also uneventful and at 24 weeks, the dose of Norlutin was reduced to 5 mg. a day.

At 12:00 p.m. on February 29, 1960, the patient was readmitted to the hospital in spontaneous labor after premature rupture of the membranes. Dilation proceeded slowly, and the patient was complete at 11:00 a.m. on March 1, 1960. Since the fetal head had failed to pass the pelvic mid plane and the fetal size seemed excessive, the patient was seen by C.A.S., who recommended a Porro Section, on the basis of cephalo-pelvic disproportion in a sterile multipara. The report of the pathologist following this surgery revealed a 1525 gram uterus with both fallopian tubes and ovaries amputated.

Infant:

The birth weight of the infant was 11 lbs. 3 oz.; the length 24 inches. The hospital course of the infant was normal. The direct Coombes

was negative, the hematocrit was 33.5, and direct bilirubin levels were .9 to 1.0 mg. The discharge weight on the 7th day was 10 lbs. 2 oz.

Discussion:

The view that the ovaries, or at least the corpus luteum of pregnancy, are essential to the maintenance of early gestation is frequently heard. This theory is based on the pioneer work on progestational steroids by Brown and Venning (1939), who concluded that ovarian loss, or failure prior to the 70 to 100 day of gestation, would usually lead to abortion. The clinical facts available on ovarian castrated patients do not support this, however, and about the last decade, students of reproductive physiology began to exhibit consideration variation in delineating the gestational age at which bilateral oophorectomy (or removal of the corpus luteum) would affect the fetus. For example, Best puts the critical period at 4-5 months, Page at 2 months, Bard at the first month, and Eastman at sometime before implantation is completed.

A comparison of abortion rate in these cases, and that of pelvic surgery during pregnancy, with the usual accepted spontaneous rate of about 10% for uterine pregnancy, is illuminating. The abortion rate in these 17 cases, where surgery took place before the 60th gestational day, is 23.5%; the rate when surgery is done during the 3rd month of pregnancy, as reported in studies by Andrews, McKerron, and Ask-Upmark, averages 11.4%.

We might conclude then, that ovarian ablation, prior to the 60th gestational day, carries about twice the risk of abortion as it does subsequent to that time. Furthermore, it would appear that if surgery is done during the third month, it carries no increased fetal risk, since the abortion rate is almost identical with that of the spontaneous rate in uterine pregnancy.

The final conclusion, then, is that the abortion rate in total ovarian ablation, prior to the 60th day, is twice that which may be expected in a patient with both ovaries.

There are many other factors, however, that make conclusion drawing in these cases somewhat hazardous. A few of these are (1) the effect of pelvic surgery on abortion rate, (2) the effect of substitutive steroid therapy, and (3) the fact that bilateral oophorectomy does not always mean total ovarian ablation.

The average abortion rate in ovarian surgery as reported by Renny, Grimes, and Chowdhury, is 15.5%. This is somewhat higher than the spontaneous rate, but certainly not enough to make surgical trauma an important factor in fetal loss subsequent to the 60th day of pregnancy.

The effect of substitutive steroids in these cases is a matter of speculation. We believe that only in the patients of Sheldon and Ottolenghi-Prete could the dosage of the agents used be considered anything approaching ovarian replacement therapy.

In reviewing any series of "complete" bilateral oophorectomies, a somewhat skeptical view is wise. Olettle has reported seven cases of bilateral oophorectomies in which pregnancy occurred at a later date; in three of these cases regular menses followed surgery. Ahnquist, in a plea for ovarian conservatism, has reported two similar cases. Machado has presented the history of a 26 year old patient who had a term pregnancy five years after a complete bilateral dermoid cystectomy.

We may conclude then that in these series of 17 cases, where the ovaries are removed before the 60th day of gestation, more than 75% went to term without adequate substitutive therapy.

A higher rate of abortion is present if surgery is done prior to the 60th day, than if done subsequent to this time. This may be due to additional protective ovarian effect, or to the increase in susceptibility of the pregnant patient to surgical trauma at this time, or perhaps both.

Summary:

(1) A case history is presented in which a term pregnancy with Porro Section followed total ovarian ablation at the 43rd day of gestation.

(2) A similar series of 16 cases is discussed with emphasis on comparative abortion rates.

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Scientific PAPER

Results of a Recent Cancer Survey for South Dakota*

By

Hubert H. Theissen, M.D.**
Rapid City, South Dakota

*Presented at the Fall Meeting of the South Dakota Society of Obstetrics & Gynecology in Huron, South Dakota, 30 September 1962

**From The Department of Obstetrics & Gynecology of Rapid City Medical Center Rapid City, South Dakota,

And Aided by The South Dakota Division of The American Cancer Society

In 1961 it was suggested by our past president, Doctor Stern, that perhaps something constructive could be done by our Society for the physicians of our state. Therefore, several committees were established, one of which was the Cancer Committee, with the understanding that each committee choose its own project. Feeling that it might be the wisest to proceed practically, it was decided to 1. determine the extent of the available cancer detection facilities in the state of South Dakota and the use of these facilities by South Dakota physicians, 2. to investigate the frequently employed modalities of therapy used by South Dakota physicians and 3. to see if perhaps we could be of some help to our fellow physicians.

With these basic goals in mind, a questionnaire was devised and circulated to 338 physicians in this state. The questionnaire was directed to general practitioners, general surgeons and members of this Society. Purposely therefore unrelated specialties were excluded from this mailing list. Mrs. Lucille H. Dory, Executive Vice-President of the South Dakota Division of the American Cancer Society and her staff were most helpful in preparing and sending these questionnaires. A total of 172 replies were obtained which I thought was an excellent response, giving approximately a 50% success ratio. However, only 155 could be used for tabulation because the other 17 replies were from retired physicians, radiologists and one osteopath. I sensed a degree of enthusiasm in the replies received which seemed sincere and

which was reassuring to me. Let me also say however, that some of the questions were left blank, making a 100% tabulation in this questionnaire impossible. The questions asked are reproduced in heavier print.

Are Pap stain facilities available to you and your area?

From the answer to this question it would seem that this method of cancer detection is available to all physicians in this state with a 100% reply. 78 physicians reported this facility to be directly in their towns or immediate area, whereas 77 had to send their Papanicolaou stains to a distant laboratory. I had thought perhaps that the predominance of Papanicolaou stains would be done only by those physicians with laboratories in the immediate vicinity; however, this was not necessarily so as evidenced by the fact that one of the two physicians with the highest number of Pap stains done per year comes from a small town miles away from a laboratory facility.

Estimate the number of Paps done in one year

The answers to this question proved to be most interesting. The number of Papanicolaou stains varied from 5 per year to 1200 per year. The vast majority of the physicians did at least 100 Papanicolaou stains per year. 18 physicans did between 101 and 200 Paps a year. 10 physicians did between 201 and 300 Papanicolaous a year. 7 physicians did above 301 to 400 Papanicolaous a year and 4 did above 400 Papanicolaous a year. 2 physicians reported doing 1200 Pap stains yearly. Another physician reported doing 1200 a year but stated that this was in connection with other members in his medical group. I would like to point out that only 39 out of 155 did more than 100 Papanicolaou stains a year.

What do you charge for a Pap stain?

The cost apparently is almost uniform throughout the state and usually did not influence the physician in doing the Papanicolaou stain. The cost varies between $5.00 and $15.00 with the average being between $5.00 and $10.00. Only 3 physicians charged $15.00; some physicians stated that they charged only the laboratory fee and made no additional charge for interpretation.

Do you do Pap stains routinely or only in selected cases?

Under this question were listed sub-groups for example: Above 30 years of age, above 35 years of age, routine prenatal or post partum, before hysterectomy, etc.

Only 44 physicians stated that the Papanicolaou stains were done routinely in their offices and 111 physicians did Papanicolaou stains only in selected cases. For example, 23 physicians started doing Papanicolaou stains above the age of 30, 26 above age 35, 40 physicians did them selectively above age 40, only 6 used Papanicolaou stains in their routine prenatal and postpartum clinics. 45 did Papanicolaou stains before elective hysterectomies for benign uterine disease, and 25 did Papanicolaou stains only when cervical lesions were present.

Do you use the Schiller test as an additional screening test?

In this group only 49 used the Schiller's test in conjunction with their cancer screening program. 106 did not. Of the 49 who did use the Schiller test, 6 used them on all cervices, 29 on cervices with lesions, and 21 used the Schiller's test to pinpoint a biopsy site. One physician stated that he was not familiar with the Schiller test, others omitted filling in this question and one of the following questions. To me, this would indicate that not all physicians were familiar with or have available a Schiller solution for this test.

Do you do cervical biopsies in the office?

62% of the South Dakota physicians do cervical biopsies in the office. This represents 96 of 155 replying physicians. 83 of these physicians do less than 25 biopsies per year, 9 do more than 25 biopsies per year and 4 physicians do more than 50 biopsies per year.

Do you use the Schiller test to pinpoint office biopsy sites?

I am unable to interpret the results of this question because 41 physicians replied that they did; previously however, the question was asked whether or not the Schiller's test was used as an additional screening method to pinpoint biopsy sites and only 21 reported that this was done.

Do you do cervical biopsies or cervical cone on all D & C patients with abnormal intermenstrual bleeding?

Perhaps this question was misunderstood by some of the replying physicians. I was interested in directing attention to the cervix and endocervix as a source of bleeding rather than the endometrial cavity. To this 96 replied that they did do a cone or a biopsy on all D & C patients with abnormal bleeding whereas 59 did not.

Are biopsies read locally?

In 79 cases, the biopsies were read locally whereas 77 had to be sent to the district laboratory. This pretty well coincided with the figure concerning the Papanicolaou stains being read at a local laboratory or distant laboratory. This would seem to indicate that only those facilities equipped with pathologists have screening facilities for reading Papanicolaou stains.

Do you use endometrial aspiration, brush or biopsy on all patients seen for cancer screening?, only those with intermenstrual bleeding?, only those with postmenopausal bleeding?

In this series, 38 did either an aspiration of the endometrium, used an endometrial brush or an endometrial biopsy on all patients for cancer screening, whereas 48 did them only on those with intermenstrual bleeding, and 49 used them only on those with postmenopausal bleeding. I was somewhat surprised to see that there were 8 who specifically stated that they had employed and were using the endometrial brush.

Given a Class II Papanicolaou stain, do you biopsy the cervix?, advise a 6 month repeat Papanicolaou?, or advise a 12 month repeat Papanicolaou?

To answer this question 64 would advise a biopsy. 86 would advise a 6 month repeat and 5 would advise a 12 month repeat Papanicolaou stain. This question is potentially important especially when many authorities state that the Class II Papanicolaou stain is many times forgotten and left without future follow-up.

Given a Class III or IV Papanicolaou stain, do you refer?, perform a D & C with multiple punch biopsy, or D & C with cold knife cone?

It is interesting to note that 97 would perform a D & C with conization, 25 would utilize D & C with multiple punch biopsy and 33 would refer such a case.

If you refer, do you refer routinely?, locally, out of town or out of state?

I had several reasons for asking this question. I felt that many times our cancer patients were being treated elsewhere, particularly at the Mayo Clinic, or perhaps Denver, or at the University of Minnesota. This question would also explore the availability of qualified men in this state to treat carcinoma as judged by their fellow practitioners in their community or in the nearby vicinity, and the answers ran as follows:

Refer locally — 53; Out of town — 53; Out of State — 23. As you may notice, the number of returns does not equal 155. I am sure that included in this figure are many physicians who included their referrals to radiologists and vice versa.

Assuming that in situ carcinoma is normally treated by removing the uterus with the cervix and a generous vaginal cuff, do you refer or do your own surgery?

71 or 46% referred to another physician for this type of surgery whereas 84, or 54% did their own surgery. In other words, over one-half of the answering physicians felt themselves qualified to treat an in situ carcinoma of the cervix.

Are adequate X-ray and radium facilities available to you?

To answer this question 75 reported adequate X-ray and radium facilities available to them directly in their own towns. 73 would have to send their patients to another town in this state whereas 7 felt that adequate X-ray and radium facilities were available out of state. This figure would once again indicate as shown before, that Radiologists and Pathologists are easily available to at least 75 of the 155 replying physicians.

Given a patient with invasive squamous cell carcinoma of the cervix, do you do your own radium insertion?, consult with a Radiologist regarding radium dosage?, be present at radium applications or refer to the Radiologists completely?

The replies to this question ran as follows: 21 stated that they did their own radium insertions. 12 stated that they consulted with a radiologist regarding dosage. 21 were pres-

ent at the radium insertion and 122 referred the patient to the radiologist (or gynecologist) completely. I would like to mention that not all of the physicians who claimed to do their own radium insertions were from our larger towns in this state, and would make one wonder regarding adequate treatment, and adequate number of milligram hours given.

If carcinoma of the endometrium is found, do you refer?

To this, 76 answered that they do their own therapy and 79 reported that they referred these cases. 46 would refer them to physicians in their own towns, 37 would refer them to physicians out of their towns and 3 would refer them out of state. Of the 76 who do their own therapy for endometrial carcinoma, 55 utilize radiation in combination with a salpingo-oophorectomy and total abdominal hysterectomy, 21 utilized just abdominal hysterectomy with salpingo-oophorectomy and 3 stated that just radiation would be used, depending upon the situation. None of the 3 physicians elaborated on this question.

Do you follow all your own cancer patients?

Only 12 of the 155 physicians stated that they do not follow their carcinoma patients but 143 of the physicians reported that they do. I would imagine perhaps of these 12 physicians who do not follow their cancer patients, the reason may be that their patients may be followed by a cancer facility such as Rochester, the University of Minnesota, etc.

Is there a cancer registry in your area?

68 reported a cancer registry in their area, 72 reported that there was no cancer registry in their area, and 15 reported that they did not know. To me, the presence of a cancer registry in the area would at least seem to indicate an increasing awareness of the physicians in this area of the cancer problem particularly as to modes of therapy, classification, etc.

Do you do radical pelvic and vulvar surgery?

To this question 41 replied "yes," and 111 stated that they do not do radical gynecologic surgery. In the group of 41 that replied, "yes," some people specified that they do not do exenterations or radical vulvar surgery. It is my own feeling in seeing the addresses of some of the physicians of this group that perhaps these physicians were not doing radical surgery in the true sense of the word, and that this question may have been misinterpreted, perhaps to include the in situ carcinoma of the cervix therapy.

Would a panel of physicians on whom you could call for help and advice be helpful to you in the treating of the gynecologic cancer patient?

117 stated that such an advisory panel would be very helpful. 38 stated that the panel would not be helpful and some of these physicians qualified their remarks by stating that it would not be helpful to them because their cancer patients were referred to either radiologists or gynecologists.

COMMENTS

Personally, I felt that a great deal had been accomplished even in just generating interest about the problem. Some of the comments of the participating M.D.s are worth repeating. Two physicians thanked us for our interest in this matter, some felt that we were not aggressive enough in selling our diagnostic tools. One recommended that we use the cigarette vender approach by deluging the population with information on cancer detection and therapy. Another physician stated that he could not sell a Papanicolaou stain until a local television program on cancer screening brought people to his office asking for the Papanicolaou stain. Another physician stated that it would be interesting to repeat this survey in 5 years and still another praised "this noble effort." One physician sent along a well studied program for cancer detection and others stressed broader education of the people toward this problem.

From the results of this questionnaire, the following conclusions seem valid.

1. Papanicolaou stains are available to all physicians who were queried. Of these, one-half had their Paps read locally, the other half sent their Pap stains to a distant laboratory. However, from the numbers done by physicians in smaller towns it would seem that distance should not be a deterrent to doing a Papanicolaou stain.

2. Improvement can and should be made in the number of Paps done per year as shown by the fact that only 39 (25%) did more than 100 Papanicolaou stains per year. Just doing one Pap stain per working day should give at least a yearly total of 250 or more. Even this is a small number considering that two

people stated that they do 1200 Papanicolaou stains a year.

3. I believe that we should stress the doing of Papanicolaou stains routinely. Only 44 of 155 physicians did Papanicolaou stains as a matter of routine. I believe that age should be a determining factor in doing a Papanicolaou stain and that consideration be given particularly to doing a Papanicolaou stain prior to a hysterectomy for benign uterine disease. As we all know, cancer of the cervix is very poorly treated in someone who has had a total abdominal hysterectomy and an invasive carcinoma as found in the cervix. It is also my feeling that a Papanicolaou stain should not be done just because a cervical lesion is present. In many of these instances a cervical biopsy would prove to be more diagnostic.

4. Since only 49 of 150 physicians utilized a Schiller's test in any capacity, it would seem that this simple office procedure should be utilized much more frequently. Knowing that normal epithelium will take a deep stain with the Schiller's solution whereas abnormal tissue will not, this would serve as another simple means of screening the normal from the abnormal cervix. It should also be stressed that a Schiller's test would be very useful and helpful in pinpointing sites for office cervical biopsies.

5. Only 61% of all physicians did cervical biopsies in the office. This would indicate great neglect of a very common and diagnostic procedure, which is readily available to all physicians, and should be used in preference to a Papanicolaou stain when a cervical lesion is present.

6. Although the uterine cavity and the endometrium is responsible for most cases of intermenstrual bleeding, we must not ignore the endocervix or the cervix as another possible source of intermenstrual bleeding. It would seem therefore that if the reason for hospitalization and dilatation and curettage is intermenstrual bleeding, the physician should use some method to determine if the endocervix or the cervix is involved.

7. Because only 24% of reporting physicians investigated the endometrial cavity in all patients seen for routine cancer screening, it is strongly advised that either endometrial aspiration, endometrial biopsy or an endometrial brush be used. It is conceded that many times a dilatation and curettage may still be done if abnormal cells are found. It is equally as likely that the ordinary Papanicolaou stain would not have picked up these abnormal cells unless if the endometrium had been investigated.

8. All of the queried physicians advised either a biopsy, six month repeat Pap stain or twelve months repeat Pap stain for the case of a Class II Papanicolaou stain. We feel that this is most important and that many Class II Papanicolaou stains could conceivably develop into Class III or IV and that this group particularly should be kept under close surveillance. It would seem that either a D & C with multiple punch biopsies or a D & C with conization remains the most important diagnostic tool for the Class III or IV Papanicolaou stain.

9. The survey would seem to indicate that the vast majority of invasive squamous cell carcinomas of the cervix are referred directly to the radiologist for therapy. It is however, most important that the referring physician keep an active interest in the radio-therapy of the patient and should be aware of the milligram hours and roentgens that the patient receives. After all, it is many times the ultimate duty of the referring physician to care for these patients, at least it always seems to me that the radiologist is notoriously absent from the bedside of the patient at her demise even though he may have been the one to institute, give, and direct the therapy. Also it should be stated that invasive carcinoma of the cervix is best treated with adequate X-ray and radiation therapy and that routine radical pelvic surgery should be limited to those institutions or people with specific training and familiarity with these techniques.

10. It would seem that the treatment of choice for carcinoma of the endometrium by those physicians who actively treat this disease is a combination of radiation and surgery. Statistically this would be the treatment of choice and that surgery only be limited to early endometrial carcinomas of the clinical stage 0 and clinical stage 1 of the international classification of endometrial carcinomas. It is doubtful that radiation alone should be employed as a therapeutic measure but it has its place in palliation.

11. It is said by many that the follow-up care of the cancer patient is equally as important as the therapy. Review of many case histories would seem to indicate that many of these patients have not been seen by their examining physician since the first or second month after therapy. It is therefore strongly advised that each cancer patient have a regular number of specified visits at regular intervals for at least a minimum of 5 years. In this way, the progress of the patient, success of the therapy or onset of new treatment can be achieved early in the event of recurrent disease. Follow-up care of the cancer patient is a duty and responsibility of all physicians who treat this problem.

12. It would be ideal if an advisory panel of qualified and interested physicians be set up and made available to all physicians with either a diagnostic or therapeutic problem. I do not know whether such a plan is actually feasible or even desirable, but it could afford a great amount of help to those physicians requesting such aid.

13. I would like to take this opportunity to thank all of the physicians who were so gracious with their time in replying and answering the questions asked on the questionnaire. Nor could this work have been done without the aid of Mrs. Lucille Dory and her staff of the South Dakota Division of the American Cancer Society.

MINUTES OF JCICP MEETING

The sixteenth meeting of the South Dakota JCICP was held as a luncheon meeting at the Marvin Hughitt Hotel in Huron on March 27, 1963.

The meeting was called to order by the Chairman, Dr. M. Sanders.

Since all members receive copies of the minutes, it was moved and seconded that the group dispense with the reading of the minutes. Carried.

The Treasurer reported that since the September, 1962 meeting receipts have totaled $7.50 and disbursements $17.64 leaving a balance on hand as of March 26, 1963 of **$52.88.**

It was decided that with this balance on hand it would be unnecessary to assess the parent organization for at least another six months.

It was moved and seconded that the report of the nominating committee be accepted and that the following persons be elected to office:

C. L. Vogele, M.D. — Chairman
Florence Atkinson — Vice President
Katherine McKillop — Secretary-Treasurer

Carried.

A letter from Dr. Van Heuvelen (regarding pronouncement of death) was read. The letter is as follows:

John C. Foster, Executive Secretary
South Dakota Medical Association
711 North Lake Avenue
Sioux Falls, South Dakota

Dear Mr. Foster:

Reference is made to your letter of October 27 regarding any legal requirement for a physician to personally declare a person dead when death occurs in a nursing home or hospital.

Actually no legal requirement exists in either the Code or in Health Department regulations. The only legal requirement is the preparation of the death certificate by the physician in attendance (S. D. Code 27.0208).

Sincerely yours,
G. J. Van Heuvelen, M.D.
State Health Officer

The program was "Anesthesia — The Nurse and/or M.D.; Medical Legal Aspects, etc.". Program participants were: Sister M. Dorothea — nurse anesthetist, Thomas Kujawa — nurse anesthetist, and Chandler L. Beach — lawyer. The following is a brief summary of the points brought out by the speakers:

1. The responsibility of the anesthetist begins the night before surgery. A visit with the patient gives the anesthetist an opportunity to observe the patient and it gives the patient an opportunity to express his fears and needs.
2. Good medical practice requires that report of necessary laboratory tests and physical examination report be on the chart. These aid the anesthetist and doctor in deciding the type of anesthetic.
3. Consent to surgery — Patient must give consent with understanding. In case of a child, parent or guardian must give consent. Married minors are considered emancipated.
4. A nurse administering anesthesia under a surgeon does not practice medicine. She is merely carrying out his orders. The surgeon, however, has the right to assume that the anesthetist is competent and continually aware of the patient's condition.
5. The anesthetist is responsible until the patient has awakened from the anesthetic. Post-operative visits for 72 hours should be made by the anesthetist and recorded on the patient's chart.
6. The anesthetist is responsible for her actions at all times. However, the employer (hospital) can be sued instead of or as a party along with the surgeon and the anesthetist.
7. Custom and usage — Accepted practice of anesthesia in the community determines requirement for a certified registered nurse anesthetist, an anesthesiologist, or acceptance of the R.N. anesthetist.
8. In order to avoid legal problems in anesthesia, the best service possible should be given in:
   a. Pre and post-operative care of the patient.
   b. Keeping up with new standards of care.
   c. Keeping up proper equipment.
   d. Paper work: consent to surgery, anesthesia graphs and report of visits, etc.
9. Recommendations for consideration:
   a. Certified anesthetist in Delivery Room as well as O.R.
   b. Written consent for delivery and anesthesia.

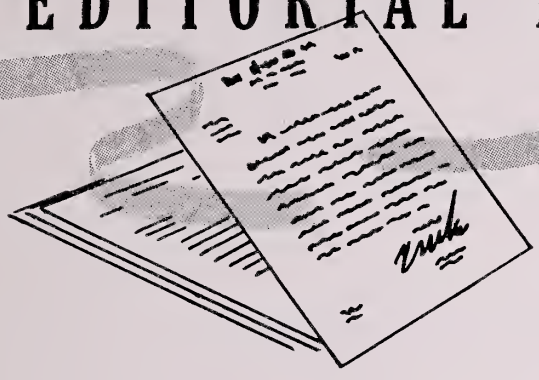
The possible dates of September 18 or 25, 1963 were suggested for the next meeting. It was recommended that the chairman, Dr. Vogele, decide the date.

"Medical audits in small hospitals" was suggested as a topic of discussion at a future meeting.

The meeting was adjourned at 3:00 p.m.

Respectfully submitted,
Katherine McKillop
Secretary, SDJCICP

EDITORIAL PAGE



PAPER WORK AND THE SHORTAGE OF DOCTORS

Despite the many advances made in the efficiency of medical and surgical practice, a physician's services are limited by the time available; the basic fact remains that there are only 24 hours in each day.

The paper work associated with medical practice has been growing by leaps and bounds the past 20 years. A great majority of patients have insurance blanks — sometimes several —which must be completed. The insurance companies are requiring letters in many instances in addition to the usual reports. There is an increasing demand for detailed disability reports which must be carefully and personally done by the physician himself, if they are to stand up under the scrutiny of various adjusters and opposing attorneys. The increasing number of law suits require that the physician's work be recorded in detail for his own if not the patient's protection. Hospital paper work has likewise been increasing, and the hospitals are rapidly increasing their employees concerned with hospital records and insurance work. Hospital charts and progress notes must be increasingly complete and in detail. Not only must the physician sign the front of the chart for the entire chart, but he must sign each order individually. The operative record must be corrected and signed. To meet the requirements of the Joint Commission each doctor must attend 50% of the meetings and must sign in for each meeting.

As a result of this increased paper work, today's physician has less time to devote to his patients, patient care and study of his individual problem cases. Not only does the quality of medicine suffer, but also the time devoted to each patient and the number of patients which can be cared for.

Unless this trend is stopped, the proposed increases in medical students will be totally ineffective in giving the public increased medical service. The medical profession can expect no help in this problem from the government which is only adding to the non-medical burden of the doctor by their socialistic proposals which carry the ever-increasing burden of paper work. The responsibility is with the leaders of our profession and with professional management experts. The medical profession must be freed from this increasing burden so that the patients may be given their due and proper time. Until this load can be lifted there will be a "shortage of doctors."

Robert E. Van Demark, M.D.



"JOE JONES IS CONFUSED"*

My name is Joe Jones and I'm from Plymouth Meeting, Pennsylvania, which, as you all know, is two miles outside of Conshohocken. I am a retail car salesman and take an interest in civic affairs. And, frankly, I'm pretty confused about the health situation in this country.

This past year particularly, through the press, television and radio, my advice was sought on rather technical professional problems. One time, even the President of the United States brought the Medicare problem to me for advice and support. Things have tapered off a bit since the recent elections, but my state representative told me the other day that 1963 will call on my knowing a lot more about welfare prescriptions, state aid and understanding of the Congressional investigations.

As I say, I'm confused as to the health picture in the United States. I remember reading that in the 19th century Germany under Bismarck introduced the philosophy of socialized medicine. Yet, in contrast, children born today in the United States have a longer life expectancy than their German cousins. In 1946, the lay press told me about the sensational National Health Service Act in Britain, but the other day I read that the average stay in American hospitals is approximately one-half the length of stay in English hospitals . . . and the almost nonexistent waiting time for elective operations in the United States is in sharp contrast with that in England. As a matter of fact, my insurance man told me of one gallant achievement in our health record, namely, that the combined efforts of research scientist, doctor, drug manufacturer and pharmacist now result in the "weaker" sex's having a six-year advantage in life expectancy over us men — who says chivalry is dead? I have always had the feeling that because we have, by far, the best health record, we have been doing right things — not wrong things! Are we supposed to vote for changes merely for change sake?

This one really confuses me: I have always thought that there was no other seizure, spasm or sneeze identical to mine occurring in anyone else — anywhere — any more than there exists a fingerprint identical to mine. (Otherwise, why would our own FBI keep more than 163 million fingerprints on file — and add more every day?) Yes, I consider myself an individual and that my seizure, spasm or sneeze is a unique and specific problem for the physician I select and it is his job to find precisely the medication to get me up out of bed. On the other hand, I read in the papers about state welfare departments limiting prescriptions for my fellow citizens to standard lists of as few as 25 drugs . . . and a lot of these drugs are the old-timers Mother used to talk about!

*Address by Henry S. McNeil, President, National Pharmaceutical Council, at NPC Annual Luncheon, Hotel Pierre, New York City, December 12, 1962.

Here's one that has me even more perplexed: In a recent issue of a business publication appeared an article entitled, "Ironic Contrast: U. S. and U.S.S.R. Drug Industries." This authoritative, on-the-spot report told me the major areas of concern in Russia are that quality remained substandard; minimum standards have become maximum standards . . . quality control is unsatisfactory. In the U.S.S.R., where quality control is enmeshed in government red tape separate from the factory, they admit quality consequently suffers. In short, the article shows how the Soviet Union is constantly altering its drug industry to follow the capitalistic United States' pattern more closely! The article's conclusion: We must be careful about quavering before criticism of our established way of doing things, and about assuming blindly that if our way has some drawback, then it is bad, and that a completely opposite method is all good.

I followed with great interest what I thought was recent medical care legislation, namely, the Kerr-Mills Act. Before I ever did see that one put into effect, I suddenly found I should be all excited about new regulations called "Drug Amendments of 1962"!

Several months ago I could not read the daily paper without running into Washington testimony as to whether or not my friend, the pharmacist down the street, was a businessman or a professional man. This was **one** technical health problem on which I could get some help; I went to him and found to my surprise that the self-employed pharmacist averages 57 working hours per week. He has enormous risks which he must assume, such as professional malpractice, public liability, product liability, etc. None of my friends seemed to know that the minimum college education required of the pharmacist is five years, costing well over a thousand dollars a year — without living expenses! I am sure none of my neighbors know that the pharmacist's recheck of the doctor's prescription prior to filling is a vital key to safety. They have no idea either of the number of times the pharmacist is called on for professional information by physicians, other pharmacists and the public.

The other day I was reading that the new drug law makes it necessary to print the generic name on the labels on all those shelf-packed bottles down at my pharmacist's. I asked him whether the same generic name on products of two different manufacturers meant that they were therapeutically equivalent; this is what most of us non-professional people have been led to believe. He certainly straightened this one out for me — briefly, he said that the generic name merely indicates the active ingredient but it cannot be assumed that all such preparations are therapeutically identical with no variance in purity, absorbency, disintegration, solubility or vehicle. I was glad to hear that because when this matter of purchasing of generics came up, all my friends began to feel that the pharmacist's prescription service reduced itself to price alone. My pharmacist put it this way: the generic equivalent philosophy now reaching ears such as mine injures the professional status of the pharmacist and falsely portrays the public's image of the pharmacist as strictly a businessman and obscures his professional status.

Not long ago, my mental gray area was further magnified. I read of stolen accomplishments of American pharmaceutical know-how being smuggled to Italy and, at the same time, saw in the public record that my own Government had been purchasing antibiotics from that same foreign country. This was hard for me to believe. The thought occurred to me, what if John Glenn had entered his Government-purchased capsule and read a sign saying, "Everything in this space capsule was purchased at the lowest possible price"? We in the automobile business would be out of business without the protection of the American patent system and, believe me, if we were out of business there wouldn't be much of a United States defense industry in an emergency!

One thing more that confuses me (but so far I haven't heard much about it) has to do with the fact that a friend of mine in a big university hospital said that his doctor told him he could not always prescribe the precise brand of drug he wanted to. This had something to do with the economics of the hospital, but it occurred to me that these — the sickest patients — should be getting precisely what their doctors want them to have.

Well, I am doing the best I can to be interested in, understand and intelligently vote on these matters — but it's a tough proposition. I was saying to my wife the other day, "Wouldn't it be a good idea to have a compulsory course in our high schools entitled, **'How to Interpret, Understand and Solve Professional Problems in the U. S.'** This could be given in the freshman year."

Speaking now as Henry S. McNeil, of the National Pharmaceutical Council, I submit these closing thoughts: Joe Jones is not alone in his feeling of confusion. He probably has 100 million fellow citizens with similar feelings. He hears the speeches, reads the newspapers and is directly approached for legislative support. He cannot count on having the daily news correctly interpreted by his physician or pharmacist — as a matter of fact, 30.5% of our people do not see a doctor at all in one given year. He sees his pharmacist more often but this relationship is not as personal as it should be. Only recently a study observed that 40% of the pharmacists did not know their customers by name. All of us allied with any segment of the American health team must make every effort to provide a united front of sound, factual information regarding our health record, of which we should be justifiably proud — not apologetic! We must maintain the **patient's** freedom of choice of physician. The **physician** must maintain the prerogative of choice of medication. And the **pharmacist** must maintain and cherish his time-honored professional responsibilities of accurately providing the specific medication prescribed.

And now, if you'll excuse a brief commercial, the National Pharmaceutical Council has the pleasure today of announcing the first edition of a truly remarkable booklet, "The Importance of Pharmaceutical Know-How." This publication, the result of many months of research, has been designed to provide factual data regarding the pharmaceutical know-how which complements the world-recognized United States Pharmacopeia and the National Formulary and scientifically clears one gray area that exists within our industry, namely, the confusion between generic terms and therapeutic equivalency. If misunderstandings such as this are resolved, we are in a far better position to paint an accurate health picture for our fellow citizens.

This booklet will be distributed and made available to any appropriate person, particularly members of the American health team. It tells its story astutely, interestingly and, above all, scientifically. It supports the fact that there is no such thing as a generic equivalent unless it is another batch of the same manufacturer's product, manufactured according to the same batch specifications and on the same machinery . . . and, most importantly, with the added assurance of a brand name evidencing the manufacturer's open willingness to assume full responsibility for his quality control.

This is good ethics, good medicine and good health insurance for our friend, Joe Jones.

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY

September 16 through 28, 1963

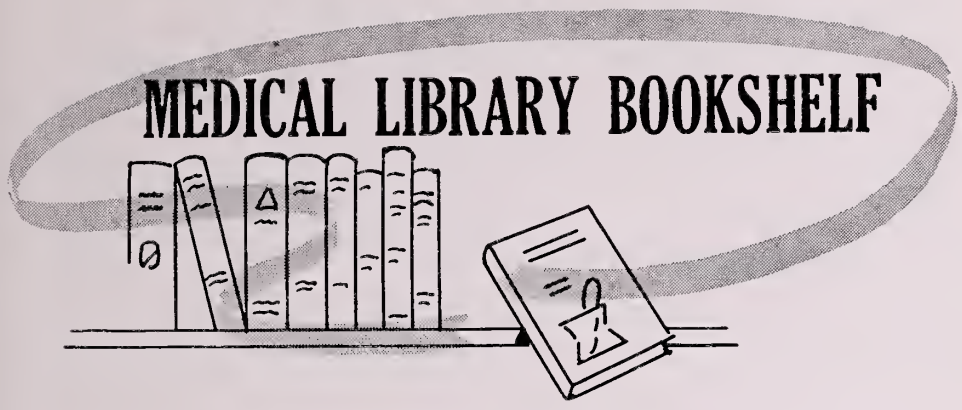
The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Bronchoesophagology from September 16 through 28, 1963, under the direction of Paul H. Holinger, M.D.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

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MECHANIZATION IN MEDICAL LIBRARIES

On April 4 and 5 this librarian had the opportunity of observing the workings of the Medlars (Medical Literature Analysis and Retrieval System) project at the National Library of Medicine in Washington, D. C. Among those who explained this project were Colonel Rogers, Director of the National Library of Medicine; Mr. Richard F. Garrard, Manager of the project which was designed by the General Electric Company, and Mr. Seymour Taine, Chief of the Bibliographic Services of the National Library.

The staff of the National Library of Medicine has been retrained in the techniques necessary for the operation of this new mechanized system. Tasks such as indexing, preparation of search requests, and proof reading are performed by people, while machines perform such operations as storage, retrieval and composition of bibliographic citations. Journals received by the library are distributed to the staff of indexers for selection of articles to be indexed; foreign titles are translated, and subject headings are assigned; all of which results in a unit record. This is punched on paper tape in a form suitable for computer input. The paper tape is read into the computer which accepts the information, processes it, compresses it, and stores it on magnetic tape.

The major publication of the National Library of Medicine is the Index Medicus which is the indispensable key to the medical journal articles through the use of the author and subject indexes. For the future publication of this, the unit records will be expanded, sorted, edited, and rewritten on magnetic tape, and once a year, merged into the annual cumulated Index Medicus.

Demand search requests will, by 1964 be processed by a staff of research specialists and converted to a form suitable for input to the computer on paper tape. The tape will be read into the computer, which will then search the files for the citations to meet the specific requirements.

The use of computers opens up a new dimension in medical library functions and services. It implies organizational, administrative, political, financial and analytical changes.

A score of scientific bodies, as well as the Council on Research, the Council on Library Resources, and the National Library of Medicine are concentrating on the use of computers. It may well be that the computer used in a medical library will need to be one that is compatible with a national centralized organization.

The publications produced by computers are machine-readable such as punched cards, paper tapes and magnetic tapes. These can be transported physically from one computer to another if compatible with the producing computer.

Under consideration is the establishment of regional libraries to serve smaller medical libraries in the areas. The input processing (acquisition, indexing, conversion, and storage for retrieval) would all be done centrally at the National Library of Medicine. The magnetic tapes comprising the files that could be searched would be reproduced and distributed to the remotely located search centers.

It may be possible to install input-output devices in outlying libraries and link the libraries by communication lines with the National Library of Medicine if compatible techniques and equipment can be installed.

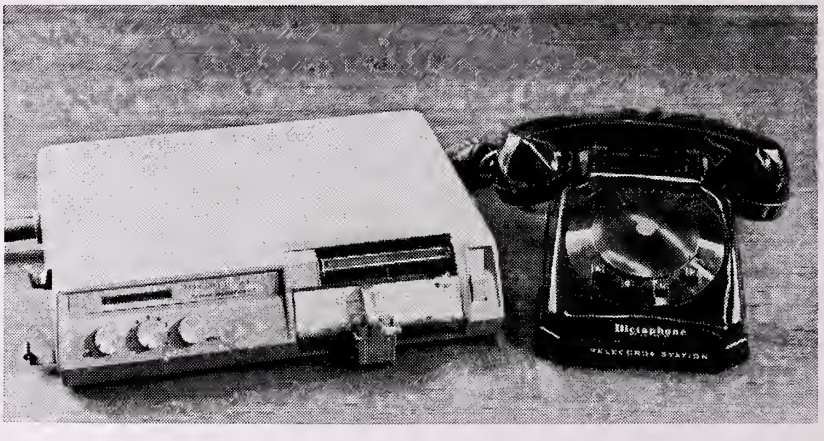
Machine retrieval of information is not a cure-all for all the problems connected with supplying the library user with data. It should however, provide the research man with timely information about the research that has been accomplished in the field of his interest in greater depth than has before been possible. It should free him from spending valuable time searching through journals for information that can be quickly supplied from the output of the computer.

According to Fred J. Bassett, Head Librarian of the Technical Library of the Upjohn Company (in Bulletin of the Medical Library Association v. 51, 1963 p. 225) if cooperative regional, national and international centers are established the outlying libraries will be relieved of acquiring much material which will be supplied by the sponsoring center. Subject analysis will be accomplished and encoded with a common, acceptable notation useable by simple or complex machines. The material will be available immediately by teletype, television, voice recording and other means with equipment in the library to copy and use transmitted information.

The librarian's place in this new machine era is yet to be determined. It is to be hoped that the librarian will not be replaced entirely by anything as cold and impersonal as a machine, no matter how efficient it proves to be for providing information. It is after all, only a tool to provide better service to the medical profession.

Esther Howard
Medical Librarian

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Pop's Proverbs

If you can laugh, you dull your opponent's arrows.

NEWS NOTES

W. B. Odland, M.D., Huron, South Dakota, recently addressed the Third District Medical Society. His topic dealt with ear surgery and deafness. **Magni Davidson, M.D.,** president of the South Dakota State Medical Association also spoke briefly at the meeting, as did John Foster, executive secretary.

* * *

Lyle Hare, M.D., of Spearfish, South Dakota has announced his retirement after over 50 years in medical practice.

* * *

Dr. Glenn Kleinsasser of Scotland was recently elected president of the medical staff at St. Michael's Hospital at Tyndall. Other officers include **Dr. J. P. Steele** of Yankton as vice president; **Dr. Sterling Berg** of Tyndall, secretary and treasurer; and **Dr. J. T. Tidd** of Yankton as chairman of the programs committee.

The 15th annual convention of the South Dakota Society of X-Ray Technicians was held in Mitchell in April.

Among the speakers on the program were **H. R. Lewis, M.D.,** of Mitchell; **F. J. Tobin, M.D.,** Mitchell, and **Warren S. Peiper, M.D.,** also of Mitchell.

* * *

Dr. and **Mrs. J. C. Smiley** of Deadwood attended the annual convention of the International College of Surgeons held on April 24-25.

On April 24, Dr. Smiley and **Dr. Adams** of Huron were inducted into the U. S. Section of the College.

* * *

The 7th District Medical Society held its monthly meeting on May 7th at the Westward Ho Country Club in Sioux Falls.

Mr. Blackie McGreevy discussed the new "Loss of Time" coverage underwitten by Combined Insurance Company, which is now available through the South Dakota State Medical Association.

Richard C. Erickson, Assistant Executive Secretary of the Association, discussed the forthcoming Annual Meeting to be held in Yankton June 8-11, 1963.

Dr. William Church presented the AMA's new film on socialized medicine entitled "Operation Hometown."

* * *

Dr. Edward R. Annis, president-elect of the American Medical Association, will be one of the principal speakers at the 17th Annual Rocky Mountain Cancer Conference, July 12-13 at the Brown Palace Hotel in Denver, Colorado.

The first day will be devoted to scientific papers presented by the guest speakers. Plans for the second day call for a panel discussion featuring the guest speakers and a Round-Table Forum.

Further information may be obtained by writing Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver 18, Colo.

The Seventh District Medical Society held a Special Meeting on Friday, April 19th, at 7:30 p.m. at St. Mary's Hall, McKennan Hospital in Sioux Falls. **Max Sadove, M.D.,** Professor of Anesthesiology at the University of Illinois was the guest speaker.

* * *

Frederick L. Votaw, M.D., VA Hospital, Sioux Falls, and **Chris Moller, M.D.,** Dell Rapids, are new members of the Seventh District Medical Society and the State Medical Association.

* * *

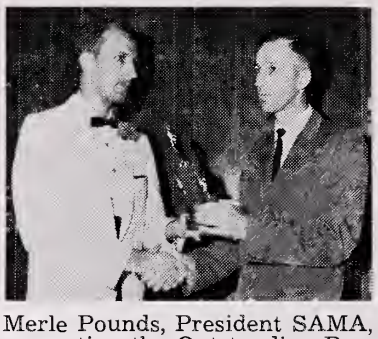
Charles J. Bobeck, M.D., Rapid City, has received his certification as a Diplomate of the American Board of Surgery, following examinations taken at Indianapolis on March 18, 1963.



Dr. Magni Davidson, President, State Medical Association, presents the State Medical Association Tuition Scholarship to Barbara Schulte, incoming freshman from Huron.

SAMA OFFICERS NAMED

Robert O. Voy, a 29 year old junior at the University of Oregon Medical School (Portland), was elected President of the Student American Medical Association for the 1963-1964 term, at the final session of the SAMA House of Delegates during the 13th annual meeting, May 5. Duke D. Fisher, 24, a junior at Indiana University School of Medicine (Indianapolis) was elected Vice President, and John W. Packer, 23, a sophomore at Bowman-Gray School of Medicine of Wake Forest College (Winston-Salem, N. C.) was named Treasurer.



Merle Pounds, President SAMA, presenting the Outstanding Professor Award for 1963 to Dr. Warren L. Jones.

FLUORIDATION ISSUE DEFEATED IN SIOUX FALLS

The Seventh District Medical Society actively participated in a publicity campaign to have the city water supply treated with fluoride, in cooperation with the local dental society. However, the issue was defeated in the city election on April 9, by a rather decisive vote.



Dean Hard presenting Robert Hanes, sophomore, with the J. A. Kittelson Memorial Scholarship, March 30, 1963. Sponsored by South Dakota Chapter of American Academy of General Practice.

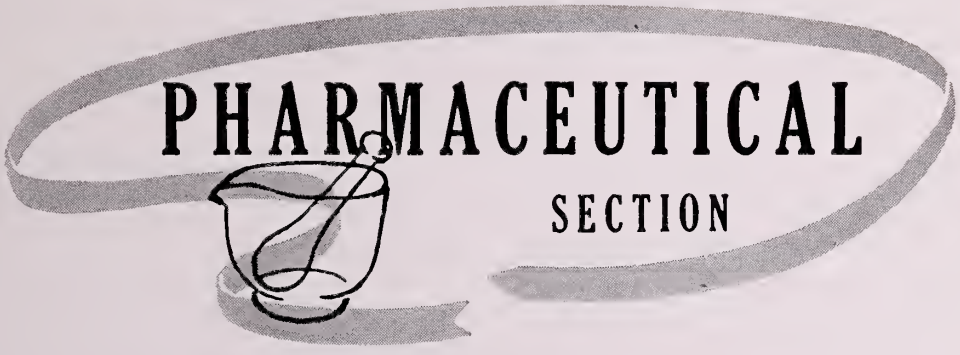
SDSMA SENDS 6 TO AMA SESSION

Six South Dakotans attended a two day legislative meeting sponsored by the AMA in Chicago on April 20-21. Representatives were **Magni Davidson, M.D.,** President of SDSMA; **Robert Quinn, M.D.,** Chairman SDSMA Legislative Committee; **H. Russell Brown, M.D.,** committee member; **A. A. Lampert, M.D.,** member of AMA's Committee on Legislation; Mrs. C. Rodney Stoltz, and executive secretary Foster.

The sessions studied the new King-Anderson Bill and its implications.

DOLAND OPENS NEW LIBRARY

A new library, built in memory of Dr. H. W. Sherwood, was recently opened in Doland, South Dakota. The idea was born in 1960, and was carried out by various individuals, organizations, and businesses in the community.



GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota



TRENDS IN PHARMACY OPERATIONS

A Preliminary LILLY DIGEST Report for 1962

Both favorable and unfavorable trends have been revealed in a preliminary **Lilly Digest** tabulation of 1,064 pharmacies.

On the favorable side, sales continued to grow and reached a record $144,727 for 1962. The gain was $5,551, or 4 percent. Prescription revenue rose $1,575 (3.2 percent); all other sales increased $4,005 (4.4 percent).

There was also a growth in the number of prescription orders dispensed. Although the number of new prescriptions filled remained virtually the same, prescription renewals increased 2.4 percent and now account for 51.7 percent of all prescriptions filled. The average prescription charge rose from $3.25 to $3.31.

The year 1962 was not without its problems. Store expenses again rose and now average 31.1 percent of sales. The gross margin remained at 36 percent; therefore, net profit (before taxes) dropped to 4.9 percent. The proprietor's total income (salary plus net profit, before taxes) also declined from 13.5 to 13.1 percent. However, the record sales volume contributed to a rise in the owner's dollar income.

The preliminary figures for 1962 indicate that the inventory rose nearly $1,500 — to $25,850. Since its rate of growth was faster than that for sales, total inventory increased from 17.5 to 17.9 percent of total sales. The growth in inventory was also responsible for the decline in the annual turnover rate from 3.7 to 3.6 times.

Good control was maintained over the prescription department investment; it declined slightly. With a rise in revenue, prescription inventory dropped from 17.1 to 16.6 percent of prescription sales. Nonprescription inventory accounted for the entire inventory increase and now averages 18.6 percent of nonprescription sales.

SUMMARY

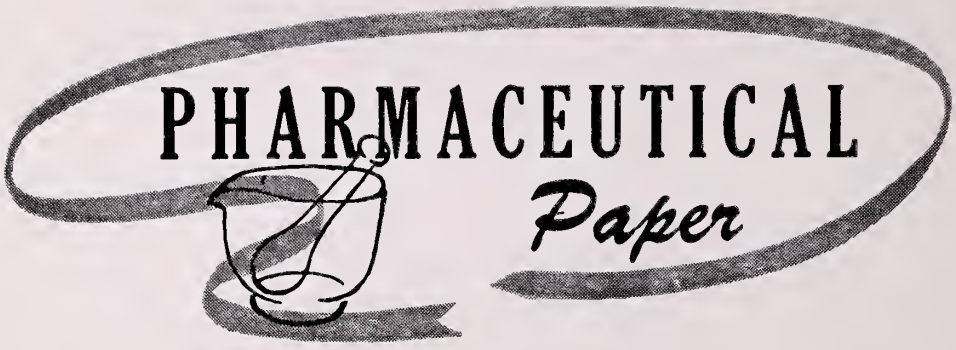
The highlights of the preliminary **Lilly Digest** tabulation of the 1962 operating figures of 1,064 pharmacies appear in the accompanying table along with those for 2,581 stores in 1961. The **Lilly Digest** for 1962, representing a tabulation of data from all reporting pharmacies, will be released for general distribution on or about September 2, 1963.

Averages Per Pharmacy	1962 (1,064 Stores)	1961 (2,581 Stores)	Change and Percent of Change
Sales			
Prescription	$ 50,719— 35.0%	$ 49,144— 35.3%	+$1,575—3.2%
Other	94,008— 65.0%	90,032— 64.7%	+$3,976—4.4%
Total	$144,727—100.0%	$139,176—100.0%	+$5,551—4.0%
Cost of goods sold	92,575— 64.0%	89,129— 64.0%	+$3,446—3.9%
Gross margin	$ 52,152— 36.0%	$ 50,047— 36.0%	+$2,105—4.2%
Expenses			
Proprietor's salary	$ 11,869— 8.2%	$ 11,595— 8.3%	+$ 274—2.4%
Employees' wages	16,657— 11.5%	15,838— 11.4%	+$ 819—5.2%
Rent	3,503— 2.4%	3,324— 2.4%	+$ 179—5.4%
Miscellaneous operating costs	13,080— 9.0%	12,128— 8.7%	+$ 952—7.8%
Total expenses	$ 45,109— 31.1%	$ 42,885— 30.8%	+$2,224—5.2%
Net profit (before taxes)	$ 7,043— 4.9%	$ 7,162— 5.2%	-$ 119—1.7%
Total income (net profit plus proprietor's salary, before taxes)	$ 18,912— 13.1%	$ 18,757— 13.5%	+$ 155—0.8%
Value of merchandise inventory at cost and as a percent of sales			
Prescription	$ 8,394— 16.6%	$ 8,400— 17.1%	-$ 6—0.1%
Other	17,456— 18.6%	15,954— 17.7%	+$1,502—9.4%
Total	$ 25,850— 17.9%	$ 24,354— 17.5%	+$1,496—6.1%
Annual rate of turnover of merchandise inventory	3.6 times	3.7 times	— 0.1—2.8%
Number of prescriptions filled			
New	7,399— 48.3%	7,402— 48.9%	— 3—0.0%
Renewals	7,919— 51.7%	7,733— 51.1%	+ 186—2.4%
Total	$ 15,318—100.0%	$ 15,135—100.0%	+ 183—1.2%
Prescription price	$3.31	$3.25	+$ 0.06—1.8%



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WHERE DO WE GO FROM HERE?*

by

Carl K. Raiser**

Philadelphia, Pa.

Everyone who gets up to address a group of pharmacy students is expected to give an inspirational talk on "The Future of Pharmacy." Well, frankly, I don't know what the future of pharmacy is. If I could predict the future, I wouldn't be here. I'd be busy buying some stock that's going up five dollars a share tomorrow, or putting a bet down on that long-shot that's coming in at Hialeah.

What I want to do today is to point out some of the things that are happening to pharmacy and the prescription drug industry. Unfortunately, I can't promise any great, sensational disclosures. Everything I'm going to say is public knowledge. I just want to put the facts in perspective, and venture a guess about what they mean to you as tomorrow's pharmacists.

Some of the developments which I'll describe may appear to be of more direct concern to the manufacturer, but they will extend to the pharmacist, too, sooner or later. It's like the stone dropped in the millpond — the biggest splash may be in the center, but eventually the ripples reach the farthest shore.

Let's begin by looking at retail prescription drug sales from 1951 through 1961. The total number of prescriptions filled increased dramatically — from 393 to 651 million. The price of the average prescription rose from $2.25 to $3.22. That meant American pharmacists were filling more and more prescriptions, at higher and higher prices. Sales figures proved it. Total retail prescription sales increased from $883 million in 1951 to $2,044 million in 1961 — an increase of 131 percent.

Today there's evidence that the annual increase in prescription revenue is slowing down and this is coupled with increasing costs. In 1961 the average prescription price held steady, with no increase. I might add right here that 1962 figures are not available. **American Druggist** commented that it was "the first time in years" such a thing had happened. While stabilized prescription prices are good news for us as consumers,

*An address presented before the Temple University School of Pharmacy, Mid-Winter Convocation, February 6, 1963.

**Assistant to the President, Smith Kline & French Laboratories.

their effect on our business may be less salutary.

Another development is that the ratio of refills to new prescriptions is changing. In 1951 refills accounted for only 41 percent of retail transactions. In 1961, refills were a little over 48 percent. That may be a bad omen, and in just a moment I'll explain why. But it also means the pharmacist is seeing his old customers more often, which is good.

While the increase in refills is due to a number of factors, one of the most important is that fewer new products are coming on the market. Paul de Haen, the well-known pharmaceutical consultant, reported 1962 the "leanest" year for new products since 1950. Only 28 new single chemical entities were introduced last year, compared to 63 in 1959, 51 in 1957. New products plus new dosage forms, which totaled well over 400 a year all through the 1950-60 decade, last year were down to 339, lowest total since de Haen began keeping records fifteen years ago.

What has happened to our new products? For one thing, the thalidomide tragedy, following on the heels of the Kefauver investigation, spurred Congress to enact new, stringent drug laws. Their effects are already being felt.

Quite naturally, these events have had an effect on those at the Food and Drug Administration responsible for administering the drug laws. Under the circumstances there could be only one result — a more cautious attitude toward New Drug Applications.

Overshadowing new laws and the FDA is a more fundamental problem — more importantly for the time being, we've outrun our basic research. We need another breakthrough like the broad-spectrum antibiotics. It would open up a whole new area for exploration. Until that happens, we're arrived at a scientific plateau. We've found a great many drugs that control or cure diseases, but new discoveries may be more difficult because the disorders that remain to be solved are more complex. Scientists are beginning to talk, for example, about "multifactorial" diseases, brought on by many causes including physical, mental and social problems, heredity and environment.

If discovery of new drugs will be more complex, it will also be more costly. The prescription drug industry as a whole spent $270 million for research last year. In every year since 1950, the industry has spent on research considerably more than one-half of all the profits it has earned.

Our industry will spend well over a quarter-billion dollars next year with absolutely no assurance that we'll have a thing to show for it. Research is unpredictable. On an average, only one out of about 3,000 chemical substances investigated will become a usable medicine. That one, however, may outweigh all the failures. As my friend Wally Werble, publisher of the **Pink Sheet,** observed at the height of the Kefauver investigation, there's nothing wrong with the drug industry that a good cancer remedy wouldn't cure.

But we haven't got that cancer breakthrough yet. New drug discoveries, like gold, are where you find them. We can't count on a steady stream of new products, such as we've had since the end of World War II, to build new markets and bigger profits. We've seen that 1962 was a lean year. There may be others.

Some of you, if you study corporation annual reports, may be thinking that, even with fewer new products, drug firms have done pretty well in the last year or so. That may be true, but how long can we keep it up?

A shortage of new products is one problem that tomorrow's pharmacist may have to face. Another is keener competition. For many years, "competition" meant the pharmacy down the street. Today it can include discount firms, supermarkets, mail-order houses and hospital pharmacies.

The hospital in particular is becoming more and more a formidable rival for the retailer. The growing tendency among physicians to handle their private practices in a medical office building near a hospital, or in an actual wing of the hospital, draws patients who are potential customers. If the physician is a staff member, he is constantly being reminded of the hospital's financial problems; and if his hospital is like most, its pharmacy is one of the few departments that shows a profit. Consequently it would be the most

natural thing in the world for the physician to mention to patients the hospital's well-equipped, conveniently located pharmacy.

According to a recent survey by **Modern Hospital,** about 75 per cent of America's 8,700 non-federal hospitals have formularies. In most cases the formulary results in a smaller inventory than the retailer's, who may stock several brands of the same product in order to fill prescriptions from any physician. With less inventory than the retailer, lower overhead, tax-free status and, often, lower prices from manufacturers, the hospital pharmacy is, to say the least, in a "most preferred" competitive position. It is a real threat to the retailer, and therefore a matter of concern to the manufacturer.

Also, the sheer increase in our hospital population, as more and more people become covered by hospital insurance, is having its effect on the retailer. It goes without saying that the hospital pharmacist has a monopoly of sales to patients in his hospital. The hospital market for ethical drug products at present is about one-fourth as large as the retail market. It will probably get bigger.

Paradoxically, however, the growing hospital market constitutes a potential threat to the hospital and hope for the retail pharmacist. It's my belief that in the long run, unless hospital pharmacies stick pretty closely to their basic function of providing drugs for patients in the hospitals, they may find themselves answering some searching questions from government regulatory agencies.

Just two weeks ago, Dean Sprowles and I heard a talk by Earl Kintner, legal adviser to the N.A.R.D. and former chairman of the Federal Trade Commission. Mr. Kintner's talk gives rise to the question of whether there may not be a violation of the Robinson-Patman Act when hospital pharmacies sell to non-hospital patients medication which the hospital obtains at lower cost than the retailer.

The hospitals will have another long-range problem, that of simply coping with the growth of our hospital population. It's sure to go up, as more and more states expand their medical care programs under the Kerr-Mills Act. The King-Anderson Bill, or some similar measure, will be heard from again. Medical care, especially medical care for the aged, is too politically popular an issue to lie dormant long.

As a matter of fact, we're the only major Western nation that doesn't have some form of compulsory national health insurance. It's a marvel that we've been able to last this long, and we won't hold out much longer unless we can develop ways to achieve the same result through private initiative. The average citizen isn't frightened one bit by the phrase "socialized medicine." A recent survey by the Opinion Research Corporation of Princeton found 65 per cent of those interviewed looked for more, not less, government intervention in the future, and weren't especially concerned about it.

I hope, for the sake of our pharmacists, that we can postpone socialized medicine in this country as long as possible. We've seen in England what can happen to pharmacists under socialized medicine. British pharmacists have been subjected to eleven major government investigations since 1948. They have been required to account for every minute spent in dispensing prescriptions by each member of their staffs. A pharmacist must be on duty at all times the premises are open, but the Ministry of Health only pays for time actually spent in dispensing. Time spent in answering queries about a prescription comes out of the pharmacist's profits on counter sales. All financial risks are borne by the pharmacist, none by the Ministry of Health. The pharmacist maintains his supply of drugs; the Ministry pays only for quantities actually ordered by the doctor, and then only six weeks or more after the prescription has been dispensed. And, after investigating the industry, the Ministry of Health decided pharmacists were making too much money. Therefore, in June, 1961, the Ministry reduced prices for 114 standard drugs.

Our American pharmacists don't need socialized medicine. They have enough headaches already. I've pointed out that they face ever-growing competition from the hospital pharmacy. They also face competition from the large-scale centralized buying connected with government agencies, state welfare programs, labor union and other health insur-

ance plans. There's a lot of it already and there's bound to be more. There's buying by government agencies, the Military Medical Supply Administration and the Veterans' Administration, for example. Labor union health plans, like those of the United Mine Workers and the Garment Workers, incorporate centralized buying. Then there is the competition of the "discounters." Already discounting has profoundly altered prescription price structures in many areas. In some cases it has hastened the downfall of pharmacies that were caught in deteriorating neighborhoods and didn't have sufficient resources to move with the population.

Altogether, I think you'll agree, the pharmacist will have his work cut out for him in the challenging years ahead.

Now that we've examined some of the factors that affect pharmacists and pharmacy, what conclusion should we draw? I think it's this: There are bright prospects for graduate pharmacists. They're needed as teachers in our schools of pharmacy. They're needed in industry. And for the young man who wants to start his own business, risking a relatively small amount of capital with excellent chances of getting it back, retail pharmacy offers a splendid opportunity.

Despite the growth of chain drug firms, there's still a place for the independent retail pharmacist. The chains and discounters aren't having it all their own way by any means. If discounting hurt the independent pharmacist, it hurt the chains even more. By attempting either to lick the discounters or join 'em, the chains produced very poor operating results in 1962. All eight of the chains listed on the New York or American Stock Exchanges ended the year at prices well below their 1961 closings. Wall Street's bearish opinion of the chains is significant because of the market's historic function as an economic forecaster. The market has virtually written off the future of low-margin drug retailing, and retail pharmacists can take this judgment into account when making long-term plans for the future.

Although in certain areas retailers have been hurt, retail pharmacy in general has weathered the discount era as well as could be expected. Retailers well established in their communities didn't have to meet the discounter's price. They only had to narrow the gap to a level where the price-cutter's lure no longer drew a majority of customers. Some people shop for bargains; others appreciate the personalized service that the independent retailer is in a position to offer.

And the independent pharmacist is wise to stress the personalized, special-service aspect of his pharmacy. He can't beat the giants at their own game. They have too much leverage in the way of large-scale purchasing and high sales volume. Instead the independent should cultivate the equivalent of the physician's bedside manner. He's in a position to know his customers by name. And, as I mentioned earlier, he's seeing his old customers more frequently. He should make the most of it. All of us like the personal touch. None of us likes to be just a number. The telephone company and the banks are meeting opposition to the numbers game they're playing as they move more and more to automation.

The independent can provide delivery service. He can list a night telephone where he can be reached in case of emergency. There's nothing like an emergency to make people remember — and appreciate — the pharmacist.

By using ingenuity, the independent pharmacist can expand his business within the health field, without greeting cards and stuffed teddy bears. One pharmacist added the specialty of fitting and servicing hearing aids. Another became his town's specialist in fitting braces, trusses, girdles and other orthopedic devices.

But the most rewarding thing one can do, in my opinion, is to work hard at what he's been trained for — the art, science, business and profession of being a first-rate pharmacist. By keeping up with latest developments in his field, he can perform a service both to physicians and his customers. By operating efficiently, on modern, up-to-date business principles, he can make the service he renders quite rewarding.

Although this is not true in metropolitan areas such as Philadelphia, smaller hospitals can be customers as well as competitors. According to Joseph A. Oddis, executive secretary of the American Society of Hospital

STOP!



Think This Over Mr. Pharmacist!

Anyone Can Sue You!

Remember—whether it is your fault or not, anyone can sue you! That's why you need Professional Liability and Premises Liability insurance.

- ✔ Professional Liability Insurance protects your reputation as a pharmacist.
- ✔ Premises Liability protects you from claims arising from accidental injury or death of anyone while in your store or on the adjoining sidewalk.

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SINCE 1909

HOME OFFICE

ALGONA, IOWA

Pharmacists, 55 per cent of the U. S. hospitals lack the services of a registered pharmacist. In many communities, independent pharmacists have taken over responsibility for the hospital pharmacy. According to Oddis, pharmacists who have made working arrangements with their local hospitals have "profited personally, acquired increased prestige through other professional practitioners, and rendered an additional service to the community."

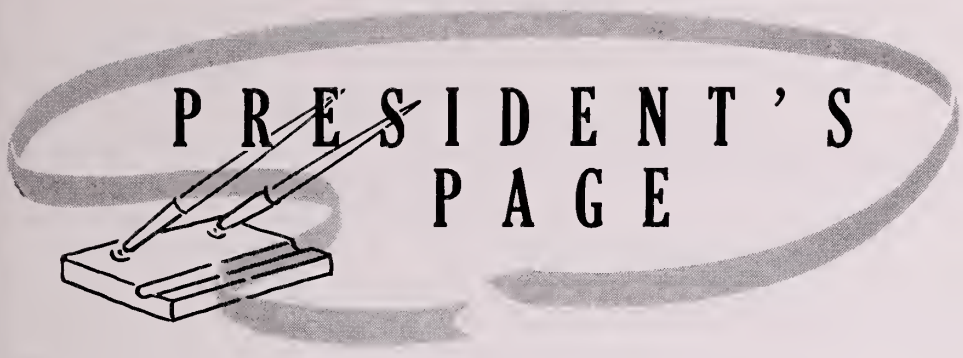
Nursing homes are another wide-open field of opportunity. The number of nursing homes increased more than 30 per cent during the past decade. There are now between 350,000 and 360,000 beds in U. S. nursing homes. There are certain to be more, since older persons are an ever-increasing proportion of our population. The King-Anderson Bill provided for nursing-home care, and new legislation along the same lines will undoubtedly have similar provisions. Moreover, nursing homes are no longer restricted to the aged. They're taking some of the pressure off our hospitals. They're treating a wide variety of conditions, and using more and more drugs to do so. If the pharmacist isn't getting his share of this business, he should be going after it.

Let me sum up. There are big changes ahead for pharmacy and the independent pharmacist. They will profoundly affect the pharmacist and his way of doing business. But there are opportunities, too, and I believe there always will be. The independent pharmacist is too valuable a man to lose.

Sir Hugh Linstead, the distinguished British pharmacist, recently described the qualities of what he called "The Independent Professional Man." He said:

"We need pharmacists with knowledge and authority who can speak with responsibility to the doctor, giving him a balanced opinion about new drugs of all kinds. We need pharmacists in day-to-day contact with the public who will be seen to be animated by professional and not commercial ideals, men and women who will be respected as individuals not only for what they know, but what they are."

We need people like that in America, too. I am sure there are many in this audience here today.





From the office of the Secretary of the N.A.R.D. comes this special bulletin:

"In November, 1962, the Judicial Council of the A.M.A. submitted the following statement to the A.M.A. House of Delegates: 'It is unethical for a physician to participate in the ownership of a drug store in his medical practice area unless adequate drug store facilities are otherwise unavailable.'"

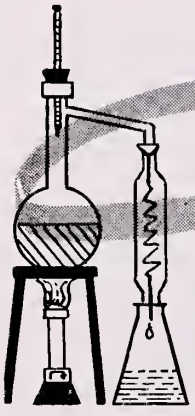
The A.M.A. House of Delegates refused to adopt this policy and referred the matter back to the Judicial Council for further study.

As a result of this study the Judicial Council is recommending the following to the A.M.A. House of Delegates for adoption at its June, 1963, meeting:

"Section 7 of the Principles of Medical Ethics provides 'Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.'" Under this language it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

The sooner the pharmacists join in a united and aggressive protest the better.

L. B. Urton
President



Advances In Drug Research

ROLE OF PHENOTHIAZINE METABOLITES ON PSYCHOPHARMACOLOGICAL EFFECTS IN MAN

Metabolic products of phenothiazine drugs formed in man may impart some of the psychopharmacological effects of these compounds, two pharmaceutical scientists report in a review of the contemporary research work and reports on the metabolism of phenothiazine drugs. The article appears as the May Review Article in the **Journal of Pharmaceutical Sciences, 52,** 411 (1963). John L. Emmerson of Eli Lilly and Co. and Tom S. Miya of Purdue University state that the results of studies on model compounds strongly suggest that the metabolic products do affect the pharmacological action of phenothiazine derivatives.

The major metabolic reactions, as classified by the authors, are: sulfoxidation, demethylation, N-oxide formation, and hydroxylation. They point out that current evidence indicates that aromatic hydroxylation followed by conjugation with glucuronic acid is the dominant metabolic pathway of the phenothiazine drugs in man. Aromatic hydroxylation does not necessarily result in a loss of pharmacological activity and studies have shown that it is possible for a phenolic metabolite to contribute to the action of the parent drug. Thus, the identification of these phenolic metabolites should be considered a task of prime importance, the scientists explain.

For example, the authors point out that investigators have shown that desmethylimipramine, a metabolic product of the phenothiazine derivative imipramine, is a more potent psychopharmacologic agent than the parent compound and there is additional evidence which indicates that the antidepressant action of imipramine is actually due to its demethylated metabolite. More remarkable, the authors note, is that the parent compound imipramine appears to antagonize the effectiveness and delay the onset of action of its metabolite desmethylimipramine.

Additionally, the possibility that the phenothiazine may be present in the body for long periods of time underscores the importance of the identification of these metabolic compounds and the role they play in the effectiveness of the drugs themselves, the workers state.

Factors such as those already mentioned and some correlations between the metabolic products found in urine and clinical changes in psychotic patients, the type of psychiatric disorder being treated, or the rate of regression after drug withdrawal have

tended to focus attention on the biological fate of phenothiazine drugs, Emmerson and Miya report. The authors conclude that with the metabolites which have been identified to date, only about 8 to 10 per cent of a dose of a phenothiazine derivate in man can be accounted for.

NEW AUTOMATED TABLET FILM-COATING PROCESS DEVELOPED FOR PHARMACEUTICAL APPLICATIONS

Problems associated with reproducibility of film thickness, characteristics, and physical appearance of film coatings for pharmaceutical tablets, particularly enteric coatings, can be alleviated with a new programmed and automated process. The process and the equipment used are described by two pharmaceutical scientists of the Ciba Pharmaceutical Co., Leon Lachman and Jack Cooper, in the May issue of the **Journal of Pharmaceutical Sciences.**

The scientists note that the chief obstacle to uniformity in the standard procedures is the inherent variability of the human operator of the coating equipment as well as certain defects in the conventional tablet-coating equipment. In perfecting the process, the authors modified a conventional pear-shaped tablet coating pan by designing and installing baffles which would insure continual and uniform tumbling of the tablets, whether wet or dry. In addition, a forced hot air duct was devised to provide controlled drying of the tablet-coats and to dry the coating-pan walls.

Another variable factor involved the application of the coating liquid and duster which Lachman and Cooper met by utilizing a hydraulic spray (airless) gun of suitable design. To further facilitate the coating process, they incorporated the duster as a suspension in the coating liquid which decreased the dust hazard and provided a means for applying more exact quantities of the duster during the coating operation.

After the mechanical components had been modified to operate suitably, the authors developed a programmer by using a Western Union tape transmitter designed for 5-unit code transmission with a perforated tape. The perforated tape travel is controlled by a timer in the control box which, in turn, controls the various functions of the coating cycle. The programmer starts the coating pan rotating, regulates a three-way solenoid which opens and closes the automatic spray gun used to spray measured doses of the coating suspension, regulates the damper of the forced hot air duct to supply the necessary air for drying the tablets, and activates a latching relay which terminates the coating cycle and shuts off the programmer.

The advantages which the authors claim for this new process include the deposition of a more even film coating which produces enteric coated tablets with one-third or less the film weight which would result from manual coating procedures, no coating build-up on the pan wall which permits continuous coating of batches of tablets without washing the pans between batches and for this same reason the possibility of pimples forming on the film coat is eliminated, and the time required to enteric coat a batch of tablets is at least half that required for the manual procedure.

The authors note that one operator can supervise the coating of many batches of tablets per day and the need for experienced tablet coating personnel is eliminated.

STUDY POINTS TOWARD LONG-SOUGHT ANTIHISTAMINE POISONING ANTIDOTE

An antidotal regimen effective against antihistamine poisoning in rats may provide a method of treating the same condition in man as described by two pharmaceutical scientists in the May issue of the **Journal of Pharmaceutical Sciences.** "Acutely toxic capabilities" of therapeutically useful antihistamines have been recognized for about 20 years, I. H. Mael of the Encino (Calif.) Hospital and J. F. Bester of the University of Southern California point out, but despite repeated efforts to find satisfactory treatment methods, antidote procedures "continue to be difficult and not overly successful."

Factors complicating the prevention and treatment of antihistamine poisonings are inconsistent dose-effect relationships and toxic symptoms of mixed characteristics. Typically, antihistamine poisoning produces drowsiness

followed by nervousness, tremors, muscle twitching, delirium, and convulsions along with respiratory depression and cyanosis, followed by unconsciousness and death. The frequency and severity of these toxic manifestations vary with different antihistamines, the authors explain, but the differences are largely quantitative.

Citing poisoning records, the authors note that a need for a uniformly adequate antidote still exists. The two scientists tested the combined abilities of chlorpromazine and dextro-amphetamine in controlling the toxic manifestations of antihistamines in rats.

The antidotal treatment for a 250 mg./Kg. oral dose of diphenhydramine, for example, was 10 mg./Kg. of chlorpromazine interperitoneally as soon as convulsions became evident and as depression developed, 0.625 mg./Kg. of dextro-amphetamine was administered interperitoneally. If depression continued or returned, further doses of 0.3 mg./Kg. of dextro-amphetamine were given. Out of a group of 42 rats given the challenging dose of diphenhydramine, 32 developed symptoms requiring treatment and 28 of these recovered. In no case was it necessary to administer more than three additional doses of dextro-amphetamine.

Other well-known antihistamines tested with good results include tripelennamine, thenylpyramine, and chlorphenamine. The challenging doses of these latter compounds were altered according to their respective potencies and the antidote protocol was appropriately adjusted.

"2 Internists Wanted." Unusual opportunity to join a young, multi-specialty group. Salary $18,000 first year with rapid acceleration to partnership. Exceptional Clinic and Hospital facilities in Midwest town of 30,000 which is the Medical Center of large trade area and a fine place to raise a family. Write Box A2, S. D. Journal of Medicine and Pharmacy, 711 N. Lake Ave., Sioux Falls, S. D.

DRUGS — THE MOST REGULATED INDUSTRY

In the United States we now have hundreds of drug laws, federal and state. Justification for their existence should depend alone on their providing adequate governmental assistance to assure safe, pure and effective drugs. Their design should be protection of the public health and not promotion of other objectives. Enforcing and administering these laws are some 190 different state agencies and several federal ones. Many states and the Federal Government have three or more agencies regulating various aspects of the drug industry. Indeed some states have agencies sharing concurrent, overlapping and even conflicting jurisdiction over drug law enforcement. By any measurement, by any criterion, the drug industry in terms of its products is the most highly regulated industry in this country. — John T. Kelly, Legislative Counsel, Pharmaceutical Manufacturers Association, to National Drug Trade Conference, Jan. 22, 1963.

WHO PAYS THE OFFICE RENT?

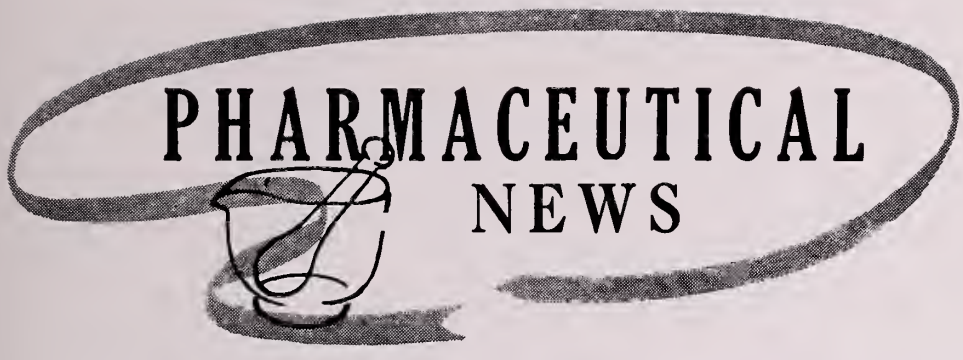
And telephone bill...and utilities...and employee salaries...*if YOU are sick or injured?*

Physicians Mutual Insurance Company (The Doctors' Company) will help pay all of your usual office expenses when you are sick or disabled—if you are the fortunate owner of our new, low-rate Office Overhead Expense Policy.

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WORK OF FORMER SOUTH DAKOTAN RECEIVES NATIONAL RECOGNITION

The Saturday Review, national weekly magazine, has announced that Parke, Davis & Company won the publication's award "for distinguished advertising in the public interest" during 1962. **Dr. George A. Bender,** formerly of South Dakota, is director of institutional advertising for the company. The firm's agency is Young & Rubicam, Inc.

Dr. Bender graduated in pharmacy from South Dakota State College in 1923 and was employed in a Watertown pharmacy. Later, he became editor of the **Northwestern Druggist** and then the **N.A.R.D. Journal** before assuming his present position. He was honored in 1958 by his Alma Mater with the honorary D.Sc. degree.

Parke-Davis' campaign, which concentrated on the present and future in pharmaceutical research, won in **The Saturday Review's** "corporate advertising" category.

According to **The Saturday Review,** the awards serve to emphasize the dignity and ethical integrity of leading companies' advertising programs, at a time when advertising is exposed to an increasing variety of criticism.

This point receives unusually strong expression in the magazine's guest editorial "The Right To Choose" by Secretary of Commerce Luther H. Hodges.

SENIOR PHARMACY STUDENTS RECEIVE AWARDS

Five members of the senior pharmacy class at South Dakota State College were recently presented awards in recognition of their achievements during their college careers. The awards are sponsored by various pharmaceutical firms and the selection of recipients is made by the staff of the Division of Pharmacy. Selection is based on scholarship, leadership and character.

Receiving the Merck & Company award was **Cornelius Maris,** Sanborn, Iowa; Bristol award, **Warren Verdeck,** Marshall, Minnesota; Lehn & Fink Medal, **Marlene Wallace,** Britton; Rexall Award, **Lola Schuman,** Stratford; and the Johnson & Johnson Dean's Award, **Kenneth Buck,** Waterville, Minn. The Johnson & Johnson Dean's Award is presented to the senior student ranking highest in pharmacy administration courses.

STAFF CHANGES ANNOUNCED AT SOUTH DAKOTA STATE COLLEGE

Changes in the staff at South Dakota State College have been approved by the Regents of Education, President H. M. Briggs has announced. Among these is the addition of another member to the staff of the Division of Pharmacy. He is **Dr. Gerald A. Bruno,** assistant professor of pharmaceutical chemistry.

Dr. Bruno has been a nuclear medical science officer in the U. S. Army since 1961.

He holds bachelor's, master's and doctor's degrees from Purdue University and has served as an industrial research chemist.

Dr. Bruno will assume his new position on July 15, 1963.

NEWS IN BRIEF FROM AROUND THE STATE

Shirley Campus Pharmacy, Brookings, has been purchased by John Moriarty and his brothers.

Ernest Greening, formerly of Dell Rapids, is now manager of the Spiers Pharmacy in Milbank.

Kenneth Odell, Valley Springs, has purchased a drug store in St. Peter, Minnesota. His stock and fixtures were purchased by Tom Mills and Ron Parks, Sioux Falls.

Ward Millar, Dell Rapids, has purchased the Cook Drug Store in Martin.

Ray's Drug Store, Brookings, has recently been completely remodeled.

Home from winter vacations are: **Mr.** and **Mrs. A. O. Bittner,** Aberdeen, from Arizona; **Mr.** and **Mrs. Leon Farrell,** Canton, from Arizona and California; **Mr.** and **Mrs. Oliver Laxson,** Canton, from California; and **Mr.** and **Mrs. Ted Hustead,** Wall, from Arizona, California and Mexico.

STUDENT PHARMACY ORGANIZATIONS ELECT OFFICERS

Officers for the 1963-64 academic year were recently elected by two student pharmacy organizations at South Dakota State College:

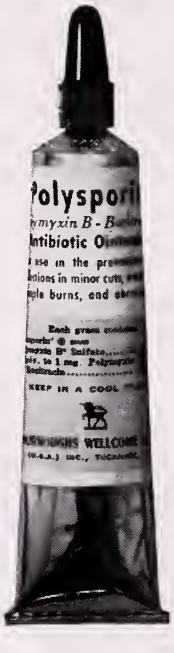
Student Branch of the American Pharmaceutical Association

President: **Garrett Gross,** Britton
Vice President: **Edward Kamolz,** Springfield, Minn.
Secretary: **Jeanne Myron,** Mankato, Minn.
Treasurer: **Dennis Hins,** Wessington
Adviser: **Dr. Gary Omodt**

Kappa Epsilon
(professional women's fraternity)

President: **Shirley Roso,** Watertown
Vice President: **Jeanne Myron,** Mankato, Minn.
Secretary: **LaDonna Gross,** Carpenter
Treasurer: **Anne Fellows,** Sioux Falls
Advisers: **Dr.** and **Mrs. Kenneth Redman**

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Supplied:** in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

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IN DIARRHEAS



Patient: W. O. **Age:** 45 **Sex:** F **Weight** 96

Diagnosis: Functional diarrhea

Results: Definite **Side Effects:** None

Comment: Patient has been on R-1132 (Lomotil) for fifteen months with definite improvement.

ACUTE

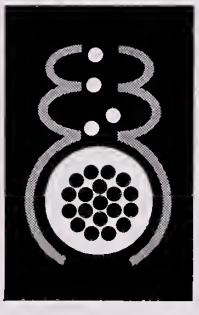
RECURRENT

CHRONIC

LOMOTIL® ANTIDIARRHEAL TABLETS / LIQUID

brand of Diphenoxylate Hydrochloride with Atropine Sulfate

PROMPT · SAFE · EFFICIENT



LOMOTIL directly controls the *mechanism* of diarrhea. Therefore, it acts to give symptomatic relief in all diarrheas.

Lomotil promptly arrests acute diarrhea and controls chronic or refractory diarrhea with a high degree of safety.

Pharmacologic considerations indicate that Lomotil acts on the smooth muscle of the intestines and thus lowers the excessive propulsive motility responsible for increased fluidity and frequency of stools. This localized action makes Lomotil unusually free of secondary effects.

By reducing excess propulsive motility, Lomotil assures safe, selective symptomatic control of virtually all diarrheas.

Dosage: For adults the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Lomotil maintenance dosage may be as low as two tablets daily.

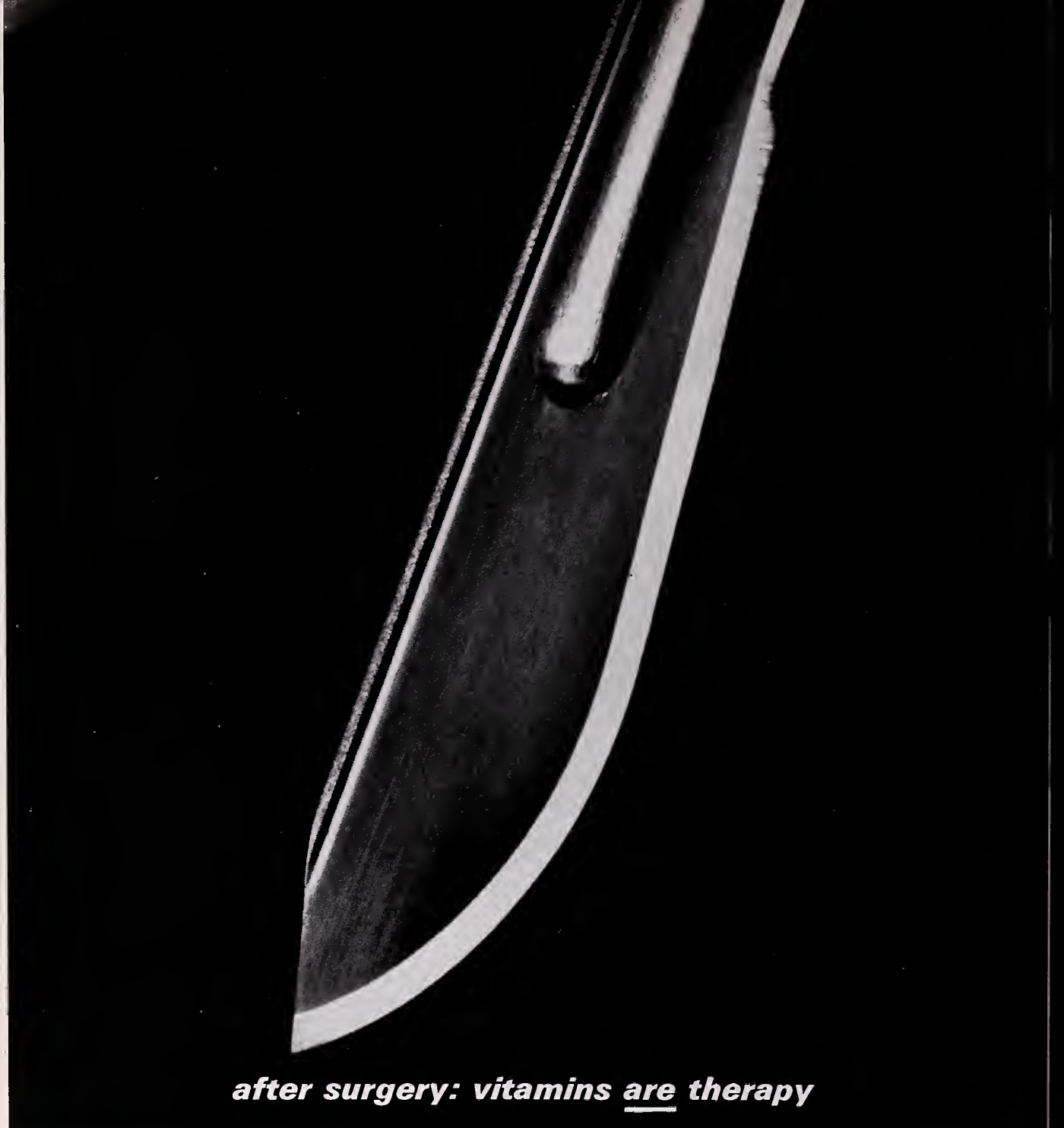
Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

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Nutritional supplementation is basic to postoperative care. Therapeutic allowances of B and C vitamins help meet increased metabolic requirements and compensate for stress depletion. STRESSCAPS can set the patient on a more favorable course and contribute to full recovery.

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline... 4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6316-3

STRESSCAPS®

Stress Formula Vitamins Lederle



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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Solfoton®

for mild, continuous sedation

Each tablet (or capsule) contains 16 mg. phenobarbital blended with 65 mg. Bensulfoid®. The Bensulfoid is an inert diluent present to permit slow absorption of the phenobarbital. The usual dosage is one tablet or capsule after meals and at bedtime. Solfoton is especially adapted to prolonged use because of its virtual freedom from depression and other side effects. Contra-indications: identical to those of ¼ gr. phenobarbital.

REFER TO PDR

Poythress, White Section, Page 808 (1963 edition) and Product Identification Section

COMPLETE INFORMATION AND CLINICAL SAMPLES SENT UPON REQUEST

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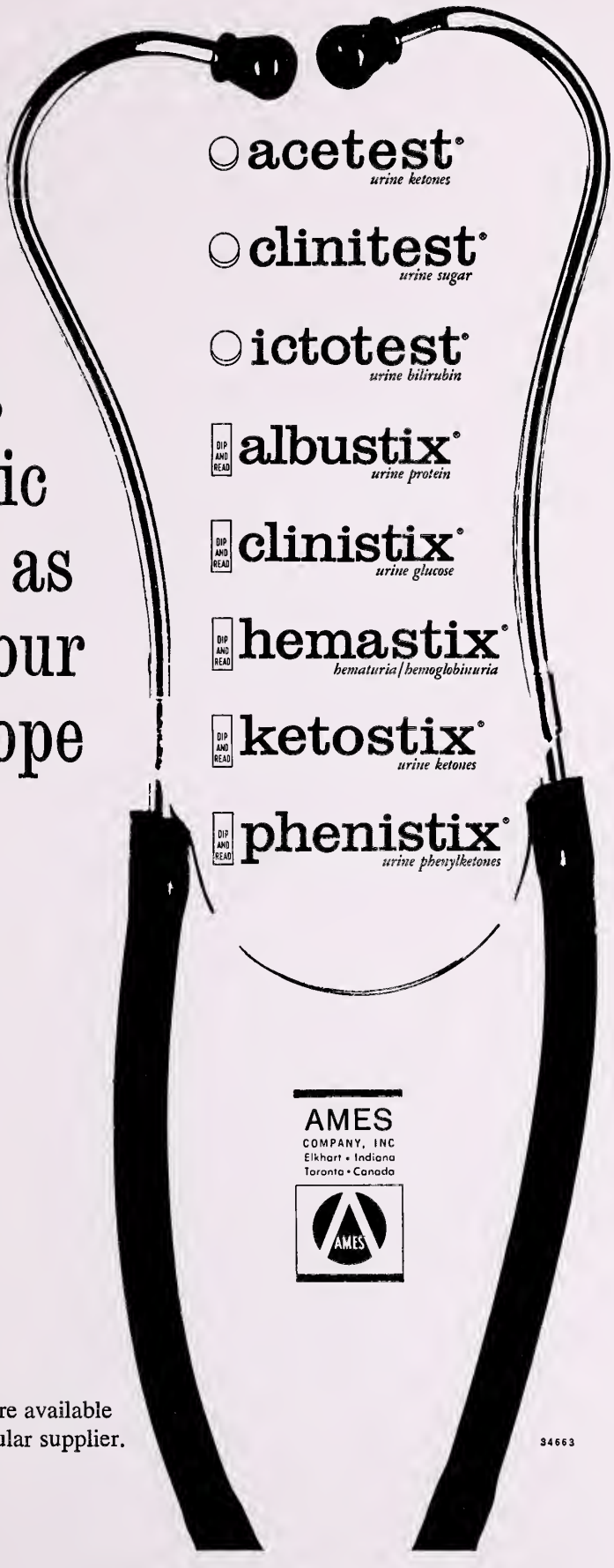
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in severe anxiety and tension, 20 or 25 mg, 3 o
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the usual initial adult dose is 50 to 100 mg I.M.
I.V.; not more than 300 mg should be given during
6-hour period. □ SIDE EFFECTS: **Oral**—Drowsine
and ataxia, usually dose-related, have been report
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tated. Paradoxical reactions, **i.e.**, excitement, stim
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be secondary to relief of anxiety and should
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quent dose-related side effects have included isolat
instances of minor skin rashes, minor menstrual
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unsteady. The injectable form has occasionally p
duced mild, transitory fluctuations of blood pressu
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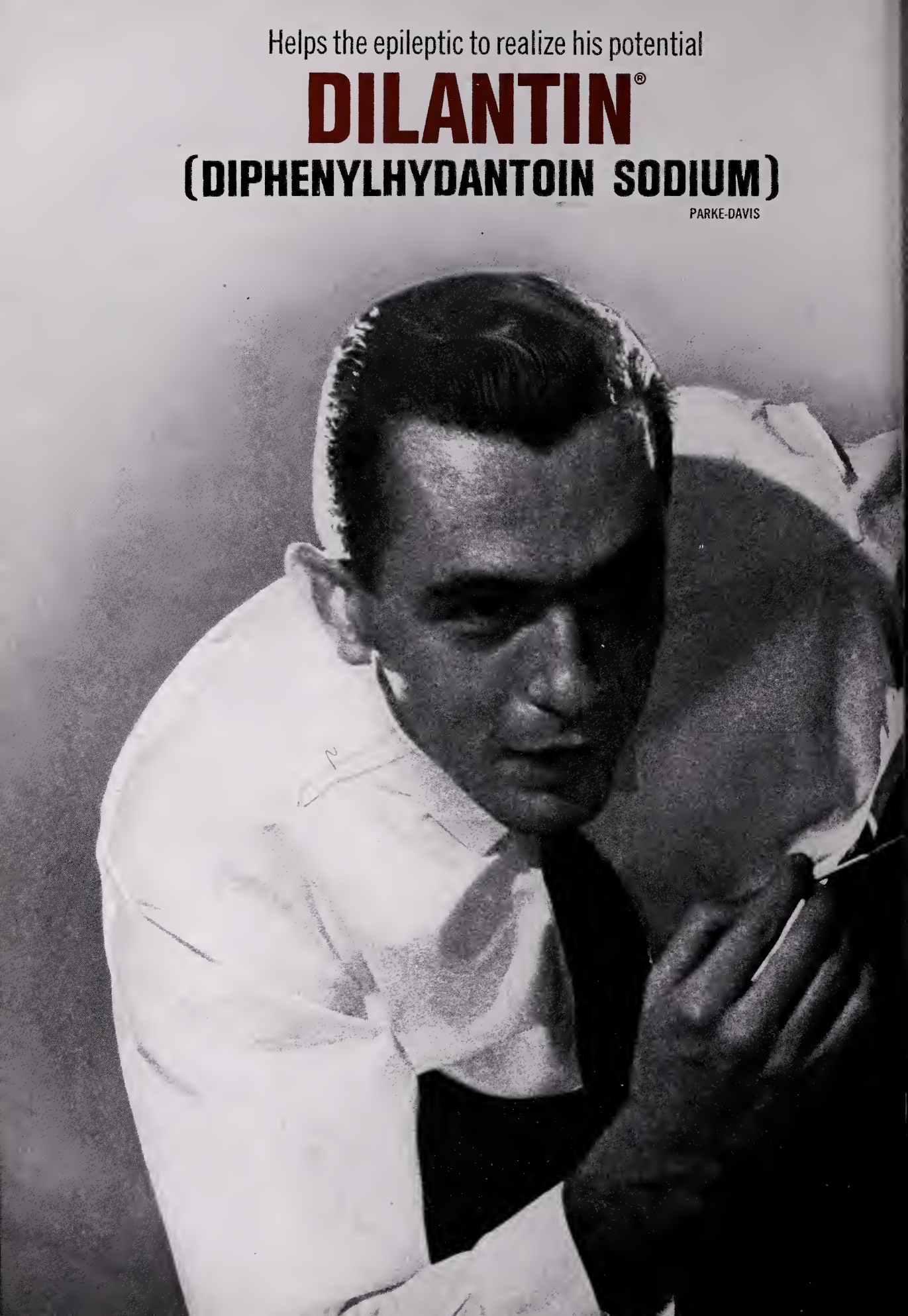
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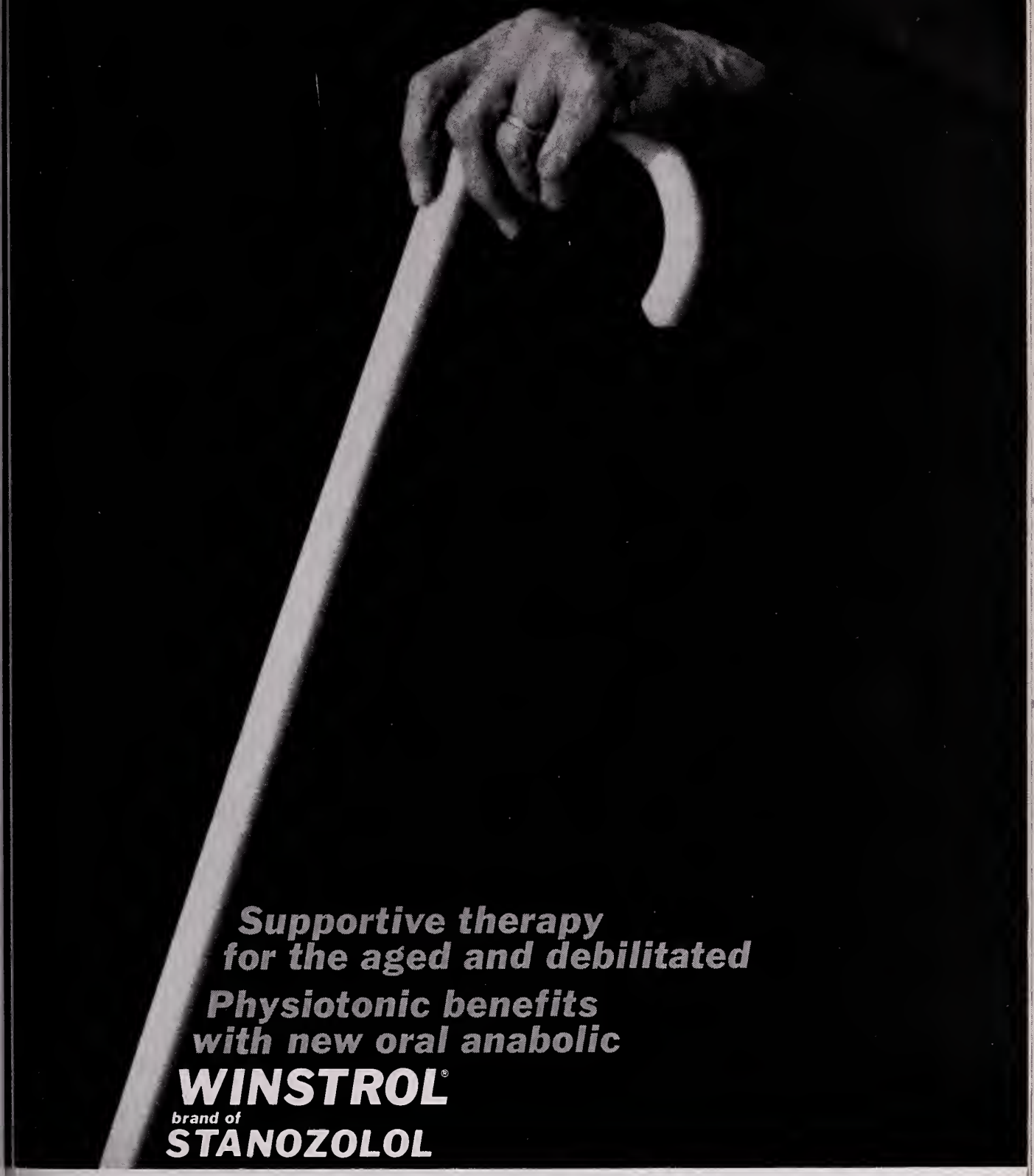
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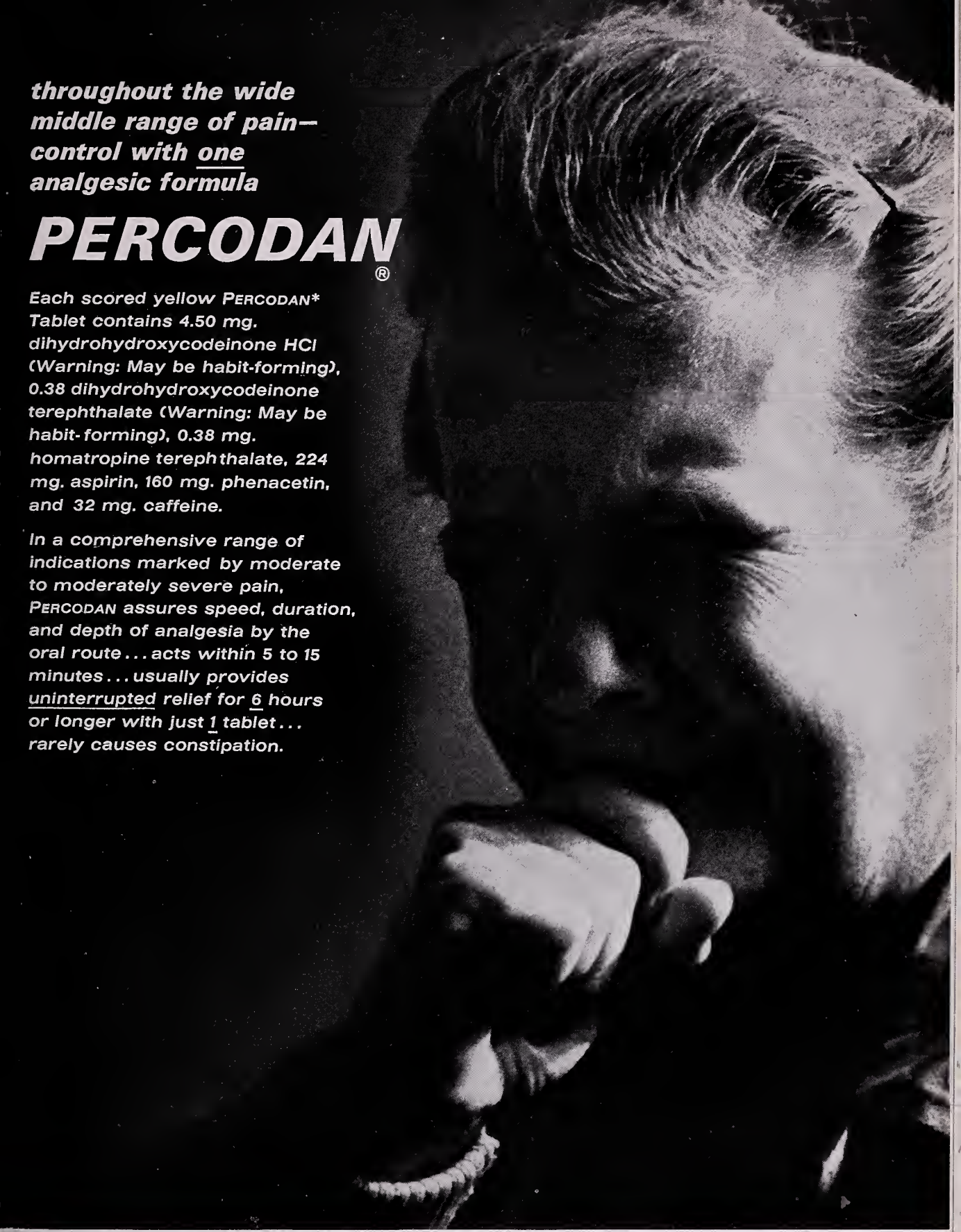
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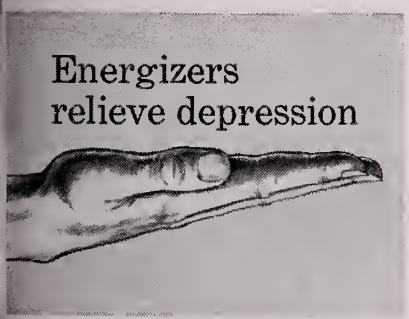
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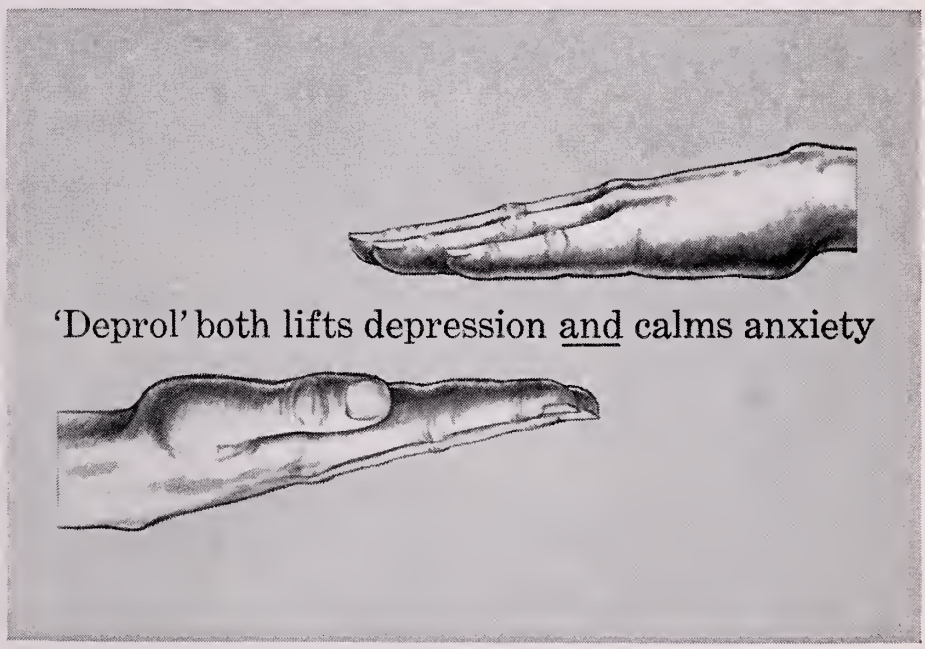
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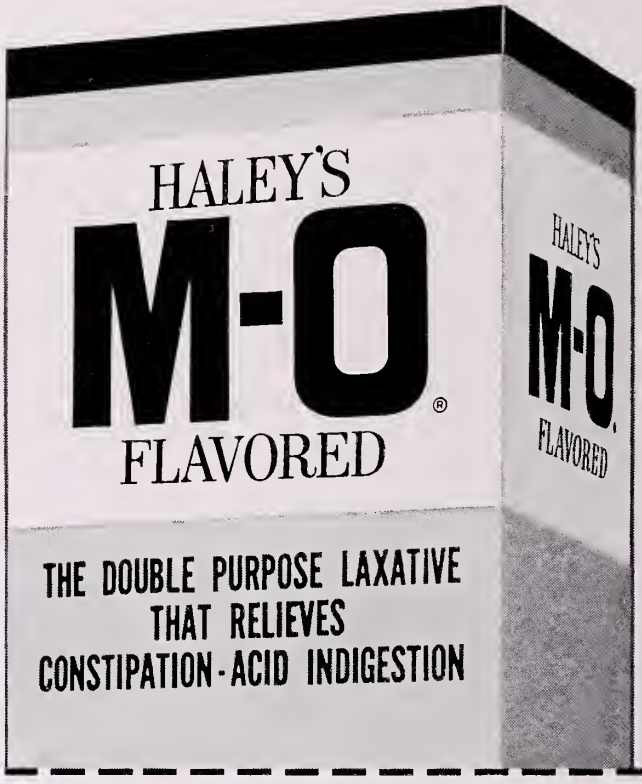
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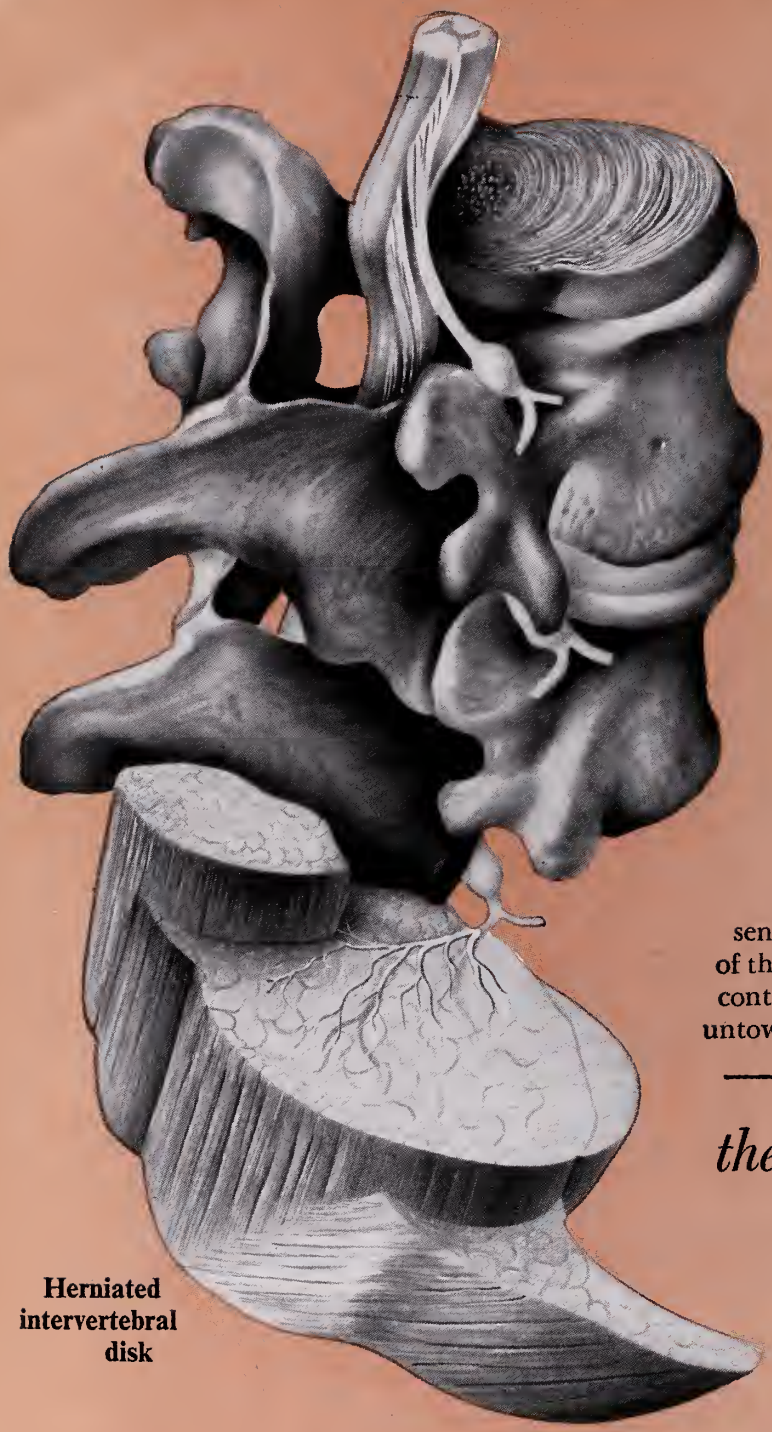
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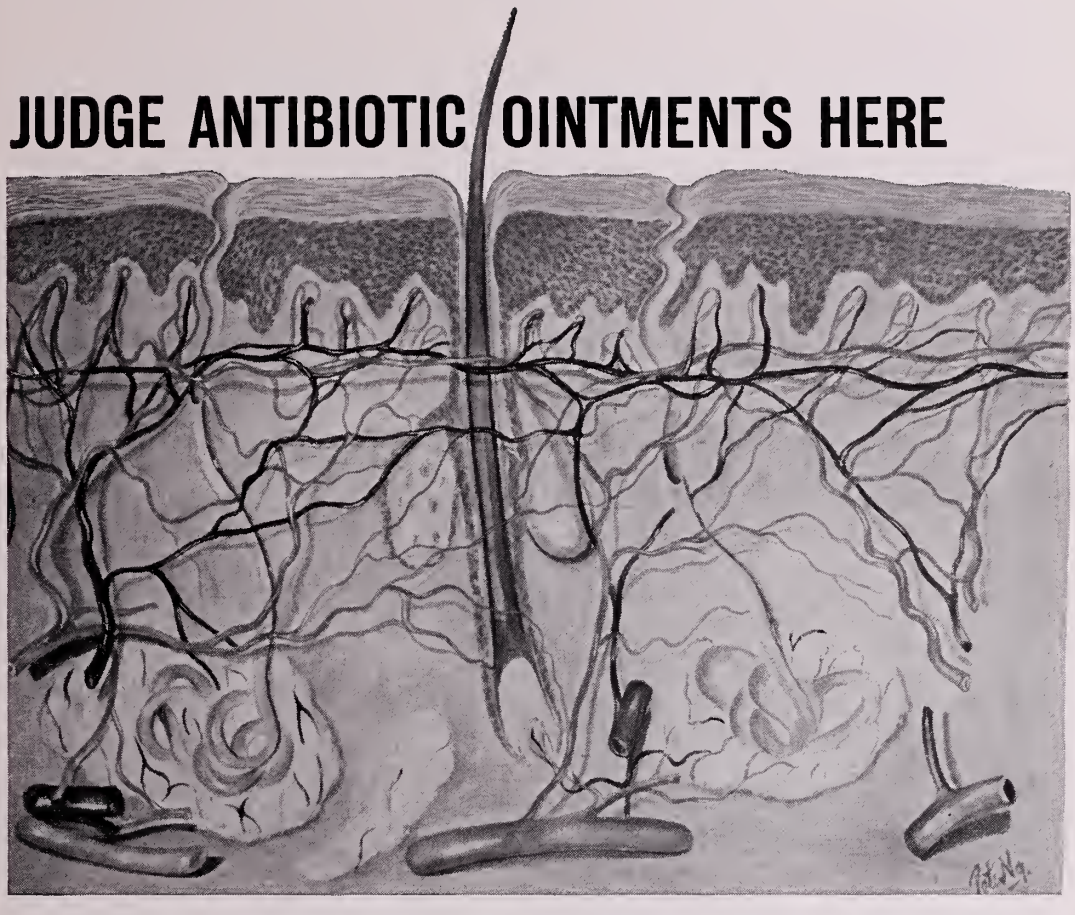
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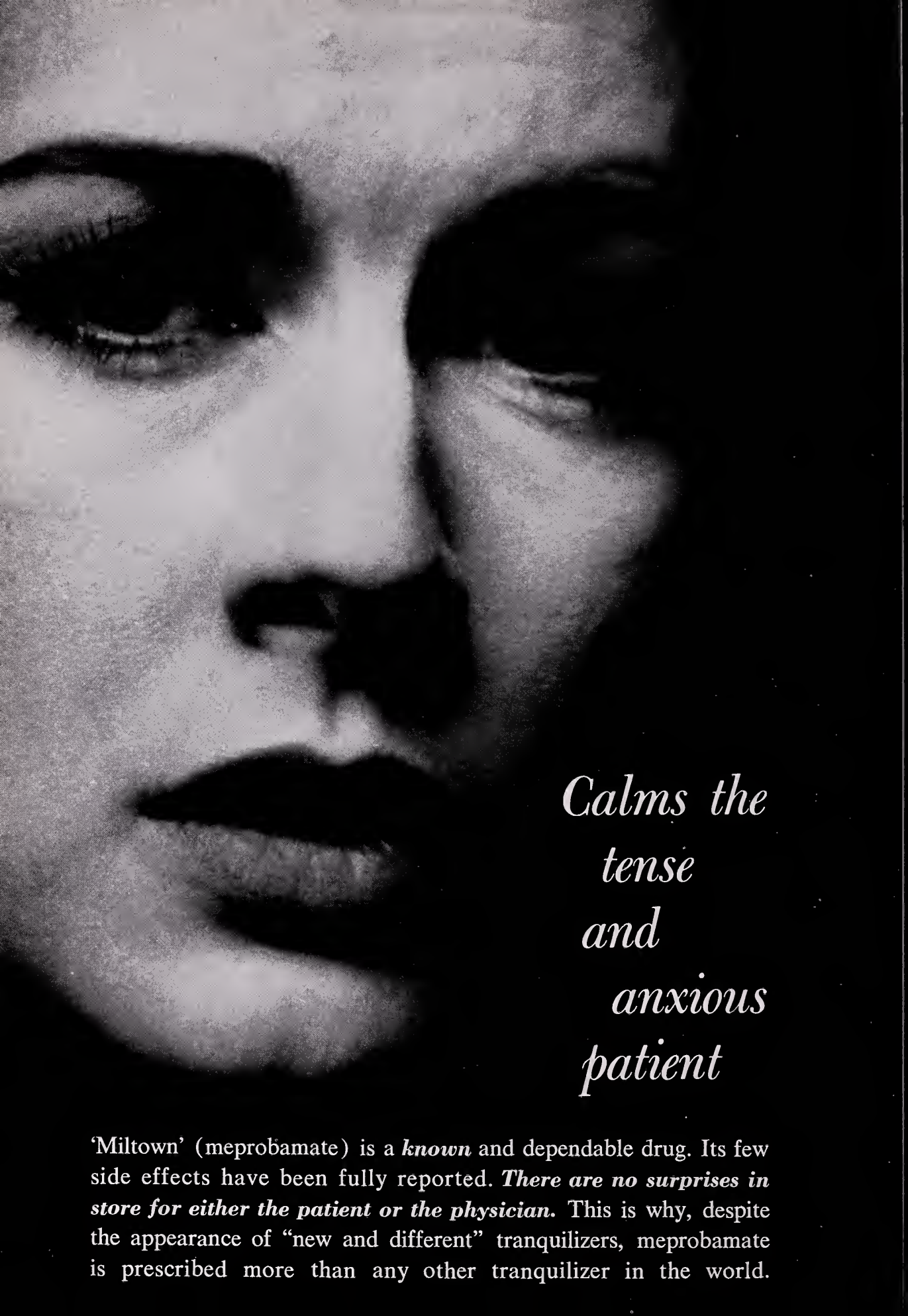
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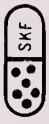
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CONTROL OF DIGITALIS INTOXICATION [1, 2]

by
W. O. Read, Ph.D.

Professor of Physiology
School of Medicine
State University of South Dakota
Vermillion, South Dakota

1. A paper presented at the scientific session of Sixty-seventh Annual meeting of the Sioux Valley Medical Association, February 21, 1963.
2. The experimental work reported in this paper was supported in part by grant H-6044 USPHS and by the American Medical Educational Research Foundation.

Digitalis intoxication leads to a variety of symptoms which include nausea and vomiting, headache, nervous irritability, visual symptoms and cardiac manifestations of hyper-irritability. It is generally recognized that the incidence of digitalis intoxication is on the increase.[1] The reasons for the increase probably derive from the fact that the treatment of congestive heart failure today involves electrolyte manipulations including salt restriction, mercurial diuretics, Diamox, ammonium chloride, and resins.[2] There is evidence that, during the development of cardiac failure, potassium is lost primarily from the body and secondarily from the myocardial cell.[3, 4] Diuretic therapy contributes to the loss.[5, 6] Present results indicate that therapeutic doses of the cardiac glycosides promote the accumulation of cellular potassium[7, 8] thus opposing the loss due to the precipitating factors in cardiac failure.

Toxic doses of digitalis invariably cause a loss of cellular potassium.[9, 10, 11] The importance of potassium ions in heart function has been known since the time of Ringer in 1878. In 1953, Schatzmann[12] reported the important observation that toxic doses of cardiac glycosides act specifically to inhibit active sodium and potassium transport. The inhibition occurs without affecting metabolism.[13] Recently an adenosine triphosphatase enzyme has been identified as part of the system for active transport of sodium and potassium.[14] The enzyme is inhibited

by toxic doses of ouabain with the result that movement of potassium into the cell is restricted. These results have been summarized by Post.[15, 16] The inhibition of cellular transport of potassium by digitalis glycosides produces manifestations of cardiac hyperirritability. The inhibition is a reversible phenomenon for, by providing sufficient potassium to compete with the digitalis for the transport site, a reversal of the toxicity is effected.[17] Potassium salts have been known to reduce or abolish ventricular premature contractions.[18] Others[19, 20, 21] have noted that potassium is promptly effective against the arrhythmias produced by digitalis. Lown[1] suggests that an effective dose is 3 gm (40 m Eq.) of potassium chloride in 500 to 1000 ml. of 5 per cent glucose in water given intravenously over 1 to 2 hours as starting dose. Alternately 2 to 5 gm of potassium chloride can be given orally as an initial dose followed by smaller doses at 8 hourly intervals, the usual therapeutic dose being 5 to 10 gm per day. Lown,[1] (p. 170) is of the opinion that the action of potassium in restoring normal rhythm in digitalis toxicity is in the nature of a physiological restitution of an incurred myocardial potassium deficit.

The administration of potassium is not without hazard. A method which would conserve cellular potassium yet exhibit none of the potential hazards of potassium administration would offer some advantages in the control of digitalis toxicity. Our own experiments conducted in the Department of Physiology and Pharmacology, School of Medicine, in Vermillion, would seem to offer some possible clue for therapy along these lines.

Some years ago we became interested in defining the possible function of taurine (2-aminoethanesulfonic acid) in the heart. We were aware that the heart contained a concentration of taurine, approximately six times that of any other tissue in the body.[22] The synthetic pathway of taurine had been well worked out for the liver cell[23] and the conjugation of taurine with cholic acid to form taurocholic acid by the liver had come under close scrutiny.[24] However, the total amount of taurine conjugated to cholic acid in the liver represents but a small part of the total taurine in the body.[25] Taurine is found in high concentration in heart tissue of the rabbit and pig[26] that do not produce taurine containing bile salts.[27] It appeared that the formation of taurocholic acid by the liver cell may not represent the main physiological function of taurine. This laboratory began a systematic investigation of the possible function of taurine in the heart.

Early in the work we were convinced that taurine was in some way controlling the irritability of ventricular tissue. We wished to determine if the compound was effective against drug induced arrhythmias.

Adult mongrel dogs of either sex were used. The animals were given an intravenous injection of sodium pentobarbital (32.5 mg/Kg). Electrocardiograms (Lead II) were recorded with one channel of a direct writing Sanborn Twin-viso recorder. Arterial blood pressure was measured from the femoral artery with a Statham P-23AA pressure transducer coupled to the second channel of the Sanborn direct writing Twin-viso recorder. The blood pressure and electrocardiogram were continuously monitored on each dog with a 17 inch oscilloscope. With the exception of some trained, unanesthetized dogs, bilateral cervical vagotomy was performed on all animals just prior to the experiment.

Digoxin (Lanoxin, Injection, Burroughs-Wellcome & Co.) was administered intravenously to anesthetized vagotomized dogs in an initial dose of 35 ug per kg followed by 17.5 ug per kg each half hour until beginning toxicity was manifest as determined by inversion of the T wave and by periods of ventricular premature contractions. Taurine was then injected via the femoral vein in a dose of 0.5 m mole/kg per 15 minutes until the electrocardiogram indicated a normal sinus rhythm.

Digitoxin (Crystodigin, U.S.P. Eli Lilly) was given orally in a small ball of ground meat to trained, unanesthetized dogs, in an initial dose of 32 ug per kg followed by the daily oral administration of 22 ug per kg. Electrocardiograms were obtained daily. When beginning toxicity was noted, as indicated on the electrocardiograms by inversion of the T wave or by clinical signs as indicated by a reluctance to accept food and by evidence of vomiting, a single intramuscular

injection of 10 ug per kg of digitoxin was given and electrocardiograms run every four hours until ventricular premature contractions appeared. Taurine was then administered intravenously in a total dose of 10 m mole per kg. The animals were followed for 30 days.

Series 1. Preliminary studies were performed to determine if taurine exhibited any toxicity toward the heart. Acute experiments were performed on ten anesthetized dogs (sodium pentobarbital 32.5 mg/kg) with vagi sectioned. The intravenous administration of 2.5 m mole of taurine per kg of body weight administered over a three hour interval had no significant effect on the heart rate, electrocardiogram or blood pressure. The mean heart rate of the ten animals was 176±7 beats per minute during the control period and 165±8 beats per minute 30 minutes after taurine injection. The mean blood pressure was 149±8 mm Hg systolic, 84+11 mm Hg diastolic, during the control period and 143±9 mm Hg systolic, 82+8 mm Hg diastolic 30 minutes after taurine injection. A complete electrocardiographic picture was obtained on three trained unanesthetized dogs for one week prior, for the 8 days during, and for 30 days following the daily administration of 2.4 m mole of taurine per kg of body weight. No changes were noted in the electrocardiogram. In one dog, a prominent sinus arrhythmia developed immediately after the injection of taurine. This lasted for approximately 30 to 60 minutes. This animal had exhibited a mild sinus arrhythmia during the control period. Eighteen adult mice (40-50 gm) were injected intraperitoneally with 1 to 5 gm of taurine per kg body weight and observed for 14 to 28 days. No toxicity was noted in any of the animals.

Series 2. A series of 8 anesthetized vagotomized dogs was given intravenous digoxin every 30 minutes until beginning toxicity developed as evidenced by inversion of the T wave progressing to ventricular premature contractions. The amount of digoxin required to produce beginning toxicity varied from 83 ug per kg to 172 ug per kg with a mean of 123±18 ug per kg of body weight. Taurine was then administered. In all eight dogs, taurine administration obliterated evidence of digoxin toxicity and reverted the premature contractions to a normal sinus rhythm. The amount of taurine required to reverse the digoxin toxicity varied from 2 to 10 m mole per kg body weight and was linearly related to the amount of digoxin previously administered to produce signs of toxicity. Figure 1

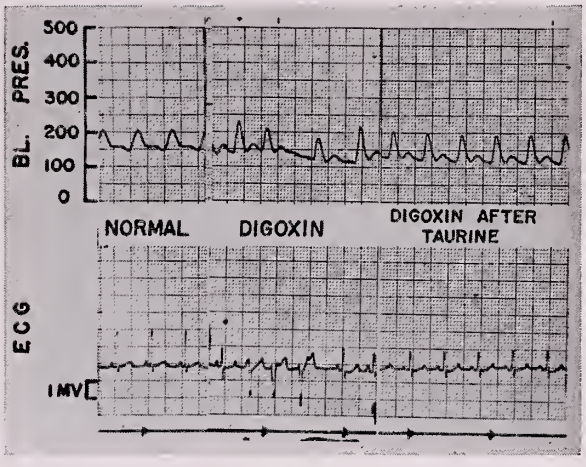


Figure 1

A sample of a record to demonstrate the effect of taurine in inhibiting the toxicity of digoxin in anesthetized vagotomized dogs. In this dog, 115 ug of digoxin/hg had been administered over a 3 hour interval until ventricular premature contractions occurred. A total of 4 m mole of taurine/kg administered intravenously, reversed the electrocardiographic signs of digoxin toxicity. Chart speed, 25 mm/sec.

is a sample from a typical record of this series and shows that taurine can revert premature contractions of digitalis toxicity to a normal sinus rhythm. In some records, where the initial amount of digoxin required to give definite signs of toxicity was high, even after establishment of a normal rhythm by taurine, the P-R interval remained prolonged. A word of caution is advisable, for in two dogs, we attempted to determine how far into toxicity we could place the animals and still have the toxicity reversed with taurine. In both animals, digoxin was administered to a total dose of 250 ug per kg body weight. In both animals, taurine administration was immediately followed by ventricular fibrillation.

Series 3. This series designed to show the effect of taurine in reversing chronic toxicity of digitoxin in trained, unanesthetized dogs. A total of eight trained dogs was used in the series. Three animals served as the control group and five animals served as the experimental groups. Digitoxin was administered

orally in a small ball of meat in an initial dose of 32 ug per kg followed by daily administration of 22 ug per kg. Electrocardiograms were obtained daily. When beginning toxicity was noted (on the 27th to 29th day of digitoxin administration), a single intramuscular injection of 10 ug per kg of digitoxin was given and the electrocardiogram followed every four hours until ventricular premature contractions appeared. Taurine was then administered intravenously in a total dose of 5 to 10 m mole per kg to the five animals constituting the experimental group. In all five of the animals, taurine reversed the digitoxin toxicity and established a normal sinus rhythm. All five of the animals lived and were followed for a period of 30 days. There have been no signs of toxicity. Figure 2 and 3 are representative of this series. All three of the control animals, not receiving taurine, died in from 4 to 8 hours after the appearance of digitoxin induced premature contractions.

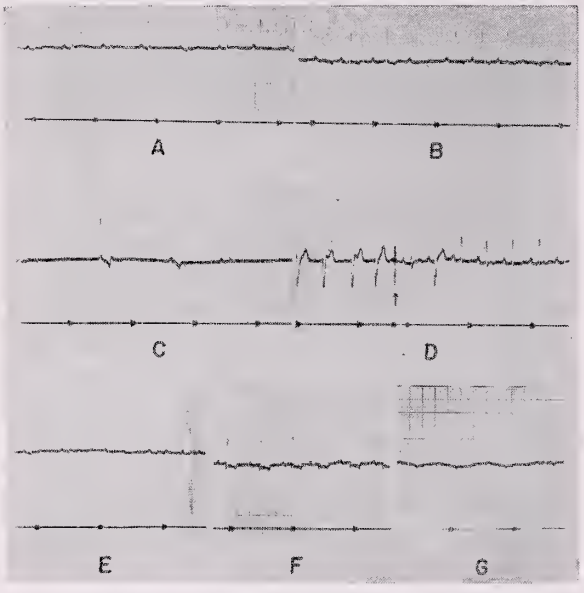


Figure 2

A sample of the electrocardiogram to demonstrate the effect of taurine in inhibiting toxic manifestations of digitalis to trained unanesthetized dogs. In this dog, a total of 732 ug of digitoxin had been administered orally over 29 days. A- Control before digitoxin administration. B- 25 days of digitoxin admin. Prolonged P-R interval, beginning A-V dissociation. C- Few hours after B, shows complete A-V dissociation. D- 29 days of digitoxin administration in which premature contractions developed. At the arrow 10 m mole of taurine 1 kg was administered i.v. over a 30 min. period, converting ventricular premature contractions to a normal sinus rhythm. E- 2 hours after taurine. F- 24 hours after taurine. G- 30 days after taurine. Chart speed 25 mm per sec. Standardization 5 mm = 1 mV.

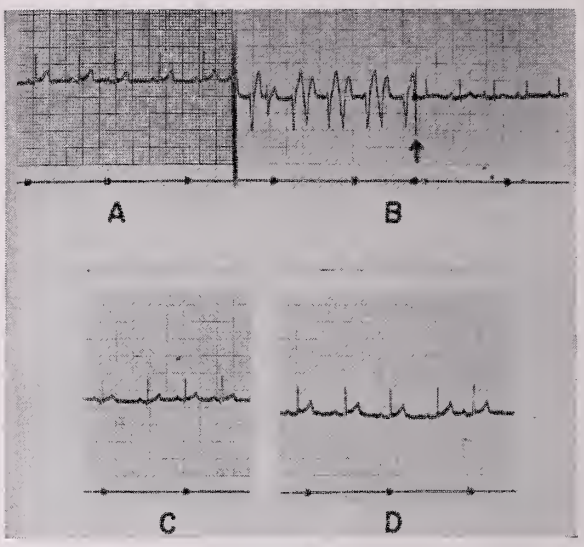
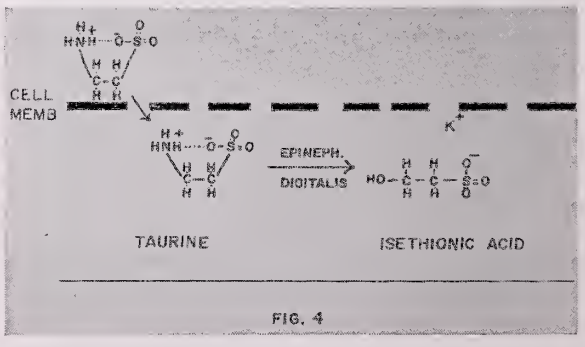


Figure 3

Sample of the electrocardiogram obtained from one of 5 trained unanesthetized dogs which had received oral digitoxin daily until toxic signs appeared. A- Control electrocardiogram taken at the beginning of the experiment. B- electrocardiogram after 27 days of oral digitoxin showing ventricular premature contractions and reversal of toxicity by taurine. At the arrow, 5 m mole of taurine/kg of body weight was injected intravenously over a 25 minute period. The reversal of toxic signs to a normal sinus rhythm begins in about 5 minutes, when short runs of normal sinus rhythm appear, and is virtually complete in 15 minutes. C- electrocardiogram 2 hours after taurine administration. D- electrocardiogram 2 days after taurine. Chart speed 25 mm/sec.

DISCUSSION. According to our present hypothesis, taurine, synthesized within the heart cell, forms a cyclic uncharged molecule by internal molecular bonding. Deamination to isethionic acid releases a charged group capable of cation attraction, presumably potassium. (Fig. 4). We believe that the taurine-isethionic acid conversion within the cell forms a relatively slow cellular metabolic system which serves to bind cations and



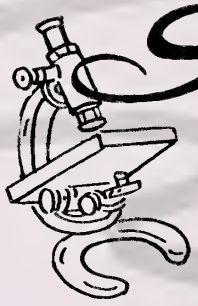
prevent the formation of spontaneous foci of discharge when the myocardial cell is subjected to a repeated physiological (or certain drug induced) depolarizing influence.

In support of the above hypothesis, we have succeeded in isolating and identifying isethionic acid from dog heart[28] and have shown that it is formed from taurine.[29] The above hypothesis also implies that in order to serve as an effective feedback control system, those factors which tend to produce foci of spontaneous impulse formation, should increase the conversion rate of taurine to isethionic acid. Unpublished observations in our laboratory show this to be the case. Epinephrine, digoxin and procaineamide increase the rate of conversion of taurine to isethionic acid. In addition, the above hypothesis suggests that isethionic acid binds potassium, thus opposing the toxic effect of digitalis. Completed, unpublished experiments in our laboratory show that, in the presence of digoxin and taurine, intracellular potassium is, in fact, increased from 25 to 30 per cent.

In conclusion, we suggest that taurine administered intravenously, gains access to the myocardial cell where it is capable of potassium binding thus preventing the loss of cellular potassium which accompanies digitalis toxicity. It is possible that taurine, non-toxic and a natural substance in the heart, may prove an effective agent in the control of digitalis intoxication.

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Scientific PAPER

WARTS *

By

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Sioux City, Iowa

Warts certainly are a problem with respect to their management; I am sure a problem for you at times — and I know often enough a problem for me. They are like the proverbial dachshund. If you give him a command and tell him "Come over here, or don't come!" — that's exactly what he is going to do. Maybe he will come and maybe he won't.

That is to say, that warts with respect to their course and response to any therapy are extremely unpredictable, and for this reason at times are quite a problem.

From the point of view of the pathologist, warts are a benign tumor of the epidermis. Like many tumors in animals, but hardly any others in man, they are caused by a filterable virus. This has been suspected for a long time, as one has been able to successfully inoculate humans with a filtrate. Recently the wart virus has been demonstrated under the electron microscope inside the cell nucleus of affected cells. Warts may be found in anybody, and on any part of the surface of the body, including the mucous membranes. They may be single or multiple. However, they are more common in children. But they do have a predilection for the face and hands.

There are various varieties of warts.

(1) The common wart (verruca vulgaris). They may be single or multiple. Not uncommonly they are found periungually, which

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complicates the situation from the therapeutic point of view.

(2) Warts of the bearded area of the face. They are usually small, but very numerous, and may be of the variety of common warts. On the other hand they may be filiform or digitate. These warts have one or numerous slender, thread-like projections. They are also commonly found in the scalp and around the eyelids.

Warts of the bearded area of the face are extremely difficult to eradicate. They are being propagated and re-inoculated by constant shaving. As soon as one gets rid of one crop, another one will frequently appear.

(3) Plantar warts. These are the same as common warts, but due to the anatomical location on the soles on which we walk, they do not have a chance to grow out, but stay imbedded in the skin, frequently being covered by considerable hyperkeratosis. They are usually very painful and it feels like walking on a marble. They may be single or multiple — sometimes quite a few of them, becoming confluent, which condition is called "mosaic warts."

(4) Flat juvenile warts. Usually found in children and young adults. They are usually, though not always, rather small, flat, papular lesions, always multiple, sometimes very numerous, on the face, top of the hands, and on the forearms. They do itch at times.

(5) Venereal warts (condylomata acuminata). They really have nothing to do directly with any venereal infection, but are usually found if there is an excessive amount of discharge present, like in gonorrhea. They are found around the male and female genitalia or around the rectum. Occasionally they are also found in the armpits and under the female breasts. They consist of larger and smaller cauliflower-like growths that may at times attain considerable proportions, become secondarily infected and malodorous, discharging considerable pus, and simulate in their appearance a squamous cell carcinoma.

THERAPY OF WARTS

It is a common occurrence that after so long warts may disappear on their own accord. This makes the evaluation of the value of any type of treatment difficult. It may have been just time for the warts to disappear at the time treatment was given. Naturally, one will credit the disappearance of the warts to the therapy given, not taking into account the possible spontaneous disappearance. Numerous and various methods of treatment of warts are available. From this multiplicity one may rightfully conclude that not any one single method is entirely satisfactory and successful.

Suggestion therapy of warts has been used quite widely and with quite convincing results. For instance, painting warts with a dye once or twice a week in a very meticulous fashion, and making quite a production out of the procedure, is one way of doing it.

Of course, any form of therapy from placebos on to x-ray therapy may have an element of suggestion in it — how much is impossible to state.

Taking up therapy of specific types of warts, we want to discuss first, (1) **Common warts.** Some form of destructive therapy is usually necessary or employed in the treatment of these warts.

This may be some slow, gradual destruction. For instance, the application of salicylic acid in the form of a small patch of 20% salicylic acid plaster over the wart, to be renewed every few days, and the scraping off of the destroyed wart tissue before each new application. In like manner, a paste made out of salicylic acid and some water may be applied to each wart. The surrounding area has to be protected with some tape into which a little window has been cut in the center for the wart, which has to be covered with some more tape after the salicylic acid paste has been applied. This, too, has to be changed every few days, removing each time part of the destroyed wart. These procedures have to be carried on until the wart has been destroyed completely.

Trichloracetic acid or bichloracetic acid or monochloracetic acid may be applied in small amounts to the warts every two to three weeks with an applicator. It may cause some painful reaction. Before each new application, whatever tissue has been devitalized has to be removed. The surrounding skin has to be protected.

In like manner, some prefer the application of phenol, glacial acetic acid or lactic acid.

Monochloracetic acid crystals may be applied to a wart for one treatment for forty-eight hours in like manner as the salicylic acid paste. This kind of treatment, however, usually causes considerable pain. The necrotic material has to be trimmed off afterwards.

Formaldehyde, as a 20% to 30% ointment, or 40% in tincture of benzoin may be applied daily to warts. Good results may be achieved in many cases, though the treatment may be prolonged, lasting not only for weeks, but maybe two or three months.

Destruction of warts by application of intensely **cold materials** frequently is successful. It may lead to blistering. The procedure is painful, but healing often is prompt and without any noticeable scarring. The procedure may be repeated as necessary every few weeks. Properly shaped pieces of solid carbon dioxide may be used for this purpose. They are to be pressed against the wart, depending on its size and thickness, for periods of twenty seconds up to two minutes and longer.

Even more convenient is the application of liquid air, liquid oxygen, or best, liquid nitrogen which has a temperature of about 300° below zero. A small cotton swab is saturated in the liquid and held against the lesion, which will freeze immediately. Unfortunately, these modalities are not available, usually, in smaller communities.

Surgical and electrosurgical methods are frequently highly successful in the treatment of the common wart.

After disinfection of the area, and local anesthesia, the wart may be grasped with a dermal curette and that way removed. Freezing the area with ethyl chloride until it gets hard materially aids in this procedure. Remnants of the wart may be trimmed off with scissors. Hemorrhage may be controlled with cautery, electrodesiccation, silver nitrate, or a gelfoam dressing. Later, dressings with an antibiotic powder or ointment will be necessary.

Electrodesiccation in local anesthesia recommends itself highly for the removal of warts. It is a bloodless procedure. After electrodesiccation of large warts it may be advisable to curette the desiccated tissue away and to redesiccate the base in order to remove all remaining wart tissue. However, one should be wary of destroying more tissue than necessary, as otherwise healing time will be prolonged, and healing will result in an objectionable and unnecessarily pronounced scar.

Some, who are particularly used and partial to this modality, prefer the use of actual cautery.

(2) **Flat warts** frequently respond to the use of a peeling cream containing resorcin and sulfur, in combination with internal administration of protiodide of mercury. This may be supplemented with peeling with ultra violet light, possibly very superficial electrodesiccation.

Also, bismuth by injection, or internally in the form of bistrimate, is being used in the treatment of flat juvenile warts, but also in the treatment of common warts.

(3) **Venereal warts** may be destroyed in local anesthesia by electrocoagulation.

They do respond to x-ray therapy, which, however, is not recommended on account of the proximity of the gonads.

These warts also do respond favorably to the cautious application of 10% podophyllin in alcohol, or tincture of benzoin. It is advisable to protect the unaffected areas with a layer of Lassar's Paste.

After a few hours the podophyllin should be washed off.

After twelve to twenty-four hours, a strong reaction with considerable inflammation and pain will occur. The growth becomes necrotic and sloughs in a matter of about three days, and healing will take place in about a week.

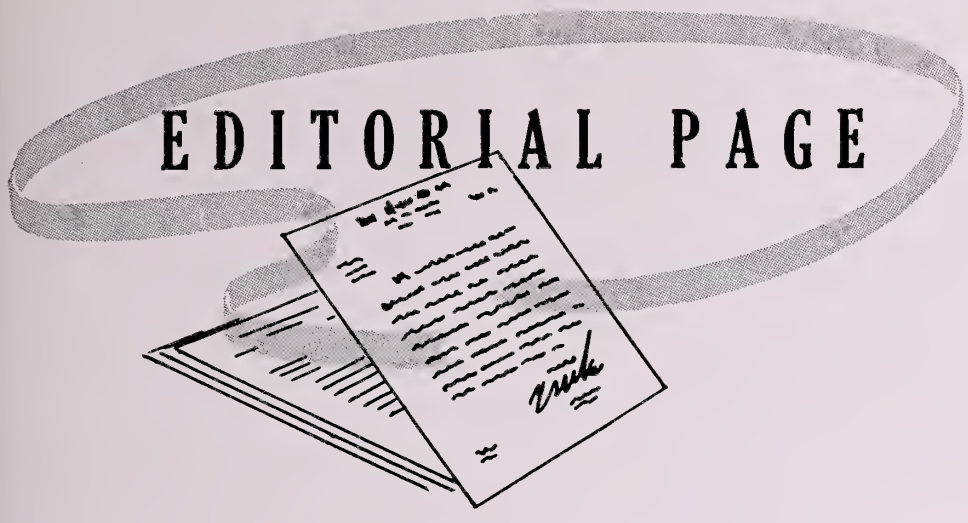
In some cases a second application may be necessary.

Recurrences are not too uncommon.

Podophyllin is highly irritating to the eye and the patient should be cautioned not to touch his genitalia and thus possibly transfer some of the drug to the conjunctiva.

(4) **Plantar warts** may be successfully treated with any of the above named slow or

(Continued on Page 33)



THE NEGLECTED ROLE OF PRIVATE PHYSICIAN IN CONTROLLING VD

Dr. F. J. L. Blasingame, Executive Vice President, American Medical Association and Dr. Arthur C. Curtis, Chairman, Department of Dermatology, University of Michigan, co-authors of a national survey of the role of the private physician in curbing the national 24% increase in lesion (infectious) syphilis made these specific comments on **South Dakota:**

385 physicians of the 500 solicited in South Dakota (78%) completed the syphilis questionnaire.

169 (44%) stated that they had treated VD during the period of study April-June 1962. These 169 physicians stated that during this period they had diagnosed and treated **14 cases of infectious syphilis — 4** of which **had been reported to** State or local Health Departments.

This American Social Health Association Study is the first valid report we have had on the extent of lesion syphilis treated privately in South Dakota and is the best indication of why we can't stem a continued annual increase of some 27%.

South Dakota, which has only two public clinics, must depend on the private physician to report the initial case.

A projection of this study indicates that some 40 cases of lesion syphilis were unreported in South Dakota during the past year and that no effort was made to find the source or spread of these cases.

The twenty-one similar cases reported last year led to the discovery of 18 **untreated** cases of lesion syphilis; and we can assume that about 35 **infected** sexual contacts of these unreported cases were lost to treatment.

Physicians are reminded of these confidential services offered by the State Department of Health to help them in the present control and eventual eradication of this community health problem:

1. Darkfield Diagnostic Service — where no pathologist is available.
2. Confidential epidemiology — initiated **only on direct permission of diagnosing physician.**
3. Referral of all local sex contacts back to reporting physician for examination. (This allows physician to supervise the whole procedure.)
4. State fee ($5.00 per visit) for examination and possible treatment of indigents.

Physicians are reminded that all records are kept on coded IBM cards and are completely confidential.

The concept of syphilis control is a simple one, but it must be predicated on the reporting of the initial case.

G. J. Van Heuvelen, M.D.
State Health Officer



LET'S KEEP POLITICS OUT OF HEALTH

by
LADD PLUMLEY

Chairman of the Board and President
State Mutual Life Assurance Company
of America

President
Chamber of Commerce of the United States

Burlington-Lake Champlain
Chamber of Commerce
Burlington, Vermont

December 19, 1962

Mr. Chairman, Ladies and Gentlemen:

When I was invited to be your speaker this evening, I must confess that I felt some qualms about coming before such an audience with a plea for preservation of our voluntary system of health and medical care for our older citizens. It struck me as rather unnecessary to hammer on the virtues of private enterprise and native American independence in a part of our country that was founded and has endured on just those virtues. I questioned whether anything I might say would not be a mere repetition of principles you have learned well and lived by for long generations past.

Perhaps all that is so, but I am going to take the risk because this issue is so vital to all of us here and in every corner of America, and because, while the eroding assault on our liberties is not new, the thrust comes this time from a new direction. And if we are not alerted and armed against it, this might well prove the most decisive thrust of all.

In just two weeks, the new Congress will convene in Washington and we will face, for the third time in the past six years, a determined, well-organized drive for health care benefits under Social Security. Make no mistake: Those who would politicalize the health problem of our aged feel themselves stronger than ever before, more hopeful of victory. Their campaign to impose Medicare upon the American people will be carried forward with all of the resources, all of the political ingenuity and all of the promotional pressure (paid for with your hard earned tax dollars) that the Administration can bring to bear. Twice rebuffed, they will hit back harder than ever.

I sincerely hope that you and others in the business community are not weary of the fight to preserve and improve our private voluntary system of health and medical care — that you are prepared to fight as hard for this principle as they are to destroy it — to substitute federal control over more people. Those who actively seek the Social Security approach are counting on our becoming so battle weary that we will quit fighting for what we believe is best for all Americans. One of their leaders has summed up this attitude in unmistakable language, and I quote:

"If not in '62, then we will pass it in 1963, and if not then we will pass it in 1964. And if we don't do it then — when we elect a President and a Congress in 1964 — we will certainly pass it in 1965." End of quotation. If we do not rise to meet each of these challenges, we will lose the war!

I would like first of all to dispel the notion, artfully and cynically disseminated by the Medicare propagandists, that humaneness and a decent concern for the aged are twin discoveries of the New Frontier. These political medicine men would have the public believe that anyone who opposes them does so out of a callous disregard for the needs of our aged fellow-citizens.

"Honor thy father and thy mother" is a commandment old and revered, not a phrase from the romances of the New Frontier nor is its observance limited to one group of our society.

Businessmen believe that every citizen, old or young, should have adequate medical care. As a group, village by village, town by town, city by city they have done more to provide it than all the political weepers since the evolution of our country. The compulsory Medicare Bill of 1962 was a callous, clumsy, inequitable attempt to solve a limited problem with a broad-scale approach. It was brain surgery with a meat axe. It was callous because we already have a majority of people over 65 covered by private insurance plans, 12 per cent protected by public assistance, and a law on the books to provide care for the remainder who need it. Nowhere have I seen or heard of the Administration urging that the states rapidly implement this law. As a matter of cold fact, its spokesmen are busy deriding the Kerr-Mills Act as insufficient while tens of thousands of the aged, in their states, in their districts for whom they profess public sympathy, and private apathy are without this medical care protection. The three million persons over 65 who were not previously covered by Social Security and who do not even have the benefit of old age payments are completely out in the cold under the Medicare scheme. It is a clumsy technique that these political surgeons are using to conduct this operation with dubious propaganda for anesthesia and a political hatchet for a scalpel. How can these federal politicians have so little faith in our local institutions or the pride of our citizens?

Since this issue is about to be joined again in the 88th Congress, this may be a good time to analyze the problem, look at the facts, and consider our course of action. Let's begin with a statement of the problem as the Social Security proponents say its exists.

First, the aged spend, on the average, about twice as much on medical care as do younger persons. This statement is true.

Second, since most aged persons are no longer working, their money incomes, on the average, are only about half as large. This statement is true.

Third, the cost of medical care is high and rising. This statement is true..

Fourth, most aged men and women are unable to finance their own health care costs. This statement is false.

The proponents of Medicare say the only solution is to increase Social Security taxes on every working person and on his employer. This money would be used currently to pay hospitals, nursing homes and home health agencies rendering services to aged persons. This "only solution" statement is false, because the Administration proposal is not the only solution. Private enterprise can do the job, and private enterprise will do the job — provided we do not let it fall into political hands, provided we keep politics out of health, federal surveillance out of sickness.

The fact that private enterprise can do the job is the first major reason why this Medicare program is both unnecessary and undesirable. This is a land made great by private business—not by the socialistic schemes of bureaucrats. Take a look at the performance record of private enterprise in the insurance of our population. In 1951, about 85 million Americans had some form of private health insurance coverage. A decade later, in 1961, that number had risen by 60 per cent, covering some 135 million Americans, or nearly three out of every four persons. Today, somewhat more than 125 million people have insurance for both hospital and surgical expenses; over 92 million have hospital insurance and insurance services other than surgery; and 34 million have the extensive benefits of major medical insurance which

was only in the very early experimental stage as recently as a decade ago.

While health insurance for the total population dates back to the 1930's, it was not until the early 1950's that private enterprise and voluntary agencies developed protection programs especially tailored to the needs of persons over 65. In 1952, probably no more than 26 per cent of the aged had health insurance. But by 1957, it was estimated that 43 per cent had this protection, and today about 53 per cent of the total aged population have some form of private health insurance. It is important to recognize that in sheer numbers of people, health insurance coverage for the aged has grown from 3 million to more than 9 million persons, or by 200 per cent. This, I submit, is a tremendous achievement in little less than a decade.

The government itself is now completing a survey of health insurance protection in our major cities and already has found that seven or eight out of every ten families have some form of coverage for their medical care.

What of the future — can we look forward to continued progress under the traditional free enterprise system? The insurance industry of which I have long been a part has made this careful estimate: because coverage is spreading so rapidly among older people today and because many more persons who are still of working age will carry health insurance into retirement, in less than seven years — by 1969 — somewhere between 70 and 80 per cent of the aged who need and want health insurance will have it. All of this assumes, of course, that the federal government does not move in and push private enterprise out. If they stifle insurance, why not the food and clothing industry — they are essential too.

While health insurance coverage has been spreading among our older citizens, something else has been going on, too. This "something else" is innovation — innovation in the administration and in the variety of plans offered to all Americans.

It is now commonplace, for example, for an employer to continue group health insurance on his employees and their dependents after the employee has retired, generally with part or all of the premium paid by the employer.

Another modification permits a retiring employee to convert his group insurance to individual coverage without being required to show proof of good health.

Still another experiment that has proved successful is coverage of groups already retired, through such organizations as the National Retired Teachers Association, the American Association of Retired Persons and the established Golden Age Clubs.

Still other changes include policies which are purchased at younger ages and are either fully paid-up at age 65 or are guaranteed renewable for the life of the individual. And there are policies available today which have no upper age limit on issuance. As a matter of fact, several companies have offered mass enrollments to senior citizens within a given state, regardless of age and without a health examination or other evidence of insurability.

Yet another outstanding example of innovation has been made possible by the action of the Connecticut, Massachusetts and New York state legislatures. These states have amended their insurance laws to permit private insurance companies to organize cooperatively to provide individual health policies at low-cost group rates. This is a massive break-through in easing the threat of financial disaster arising out of prolonged illness for millions of people over 65. Many of us in the insurance business are hopeful that these "over 65" programs can be worked out on a regional basis.

And yet, with all of this tremendous growth, innovation and experimentation in health insurance coverage, we recognize that there will always be, unfortunately, some Americans, both old and young alike, who cannot afford health insurance. Nor do they have relatives to purchase insurance for them.

How do we meet such situations? We meet them simply the way Americans always have met them: we help those who are in need, whether they are young or old. For example, it has long been public policy to provide housing only to those who truly need it. Veterans whose disabilities are not related to military service receive free hospitalization if they can't afford to pay for it. The United Auto Workers' Union helps its members out during a strike situation only if they need it. This is in the American tradition — helping those who truly need help.

This brings me to the second major reason why there is no need for Medicare. In 1960, Congress passed what has come to be known as the Kerr-Mills program of "Medical Assistance for the Aged." It is designed to help those over 65 who can meet their everyday living expenses but just can't meet some or possibly all of their medical expenses.

Congress clearly intended that eligibility requirements under this program should not be harsh. Each state has discretion to disregard in whole or in part the existence of any income or other financial resources of a person applying for medical assistance. A person can be eligible even though there is a son or daughter able to pay all or part of the mother's or father's care, and the state cannot take away the home of an older couple in need of help.

So far, 25 states, including Vermont, and three territories, with 60 per cent of the nation's aged population, have Kerr-Mills programs in operation, and five other states need only minor legislative action to become eligible. In June of this year, more than 101,000 persons were receiving medical care under the Kerr-Mills program. The total amount paid out in that month alone was $17.4 million — an average of about $170 per person.

That represents progress, but we cannot and should not be satisfied until the program is operating in every state where state residents believe it is needed. Why, may I ask do not those Medicare proponents who are truly concerned with greater protection for the aged use some of their energy to stimulate action in the 25 states still outside the Kerr-Mills program.

There is yet a third reason why the Social Security approach is not needed, and that has to do with a current myth about the economic status of our older citizens — the myth that many of our over-65 people are poverty stricken. We often hear it said that 55 to 60 per cent of our older population have money incomes of $1,000 or less a year. Let me show you how such "facts" can be grossly misleading. A housewife is classified by the Census Bureau as having "no income," even though her husband is earning say $5,000 or $10,000 a year. The same Census Bureau reported in 1960 that 24 per cent of all women 65 and over had "no income," a statistic which the Medicare supporters slyly cited to support their case. But they neglected to mention that younger women are worse off, because the 1960 census also showed that 47 per cent of all women aged 14 to 64 had "no income."

It may be statistically accurate to conclude that half of my family has "no income" because my wife is not employed. But I'm afraid my wife knows she has income — and I know it too at the first of each month— regardless of the statistician's arithmetical myopia.

And on a family basis, we find that many of the aged have at least a modest money income. In 1960, half of the 6.2 million families headed by persons over 65 had money incomes of $2,900 or more, and, where the head of the family worked full time, half the families had incomes of over $5,200 a year. A surprising number of our "senior citizens" continue to work after they reach 65 — in fact, about 3.1 million men and women over age 65 were job holders as recently as August of this year.

Nor is income the only factor to be weighed in considering the medical problems of the aged. For example, while it is true that most of our aged are no longer working, it is equally true that they no longer have the costly responsibilities of younger people who are working. Their children are grown, they no longer have to worry about clothing, feeding, housing and educating them, and they pay reduced federal income and Social Security taxes.

More importantly, many have more assets than do younger people. The 1960 Survey of Consumer Finances conducted by the University of Michigan reported that 87 per cent of the families headed by persons 65 and over had some assets, and half of those had total assets of $9,400 or more. Included in this is the home, a very important item. Government figures show that 65 to 70 per cent of our over-65 families own their own homes, completely paid for. In contrast, the survey found that only half the families headed by persons 35 to 44 years old had assets of $6,000 or more, and in the under-35 group only half had total assets of $900 or more. And — practically all of them were struggling to meet mortgage payments and raise their families.

Please don't mistake me. I'm not suggesting that our older citizens are rolling in

wealth. But the figures do show that they are in better financial shape than some people would have us believe.

Also, we have every reason to believe that tomorrow's aged will be much better off than those of yesterday or today, principally because of the tremendous movement of people under 65 into the 65 and over group. About 13 million men and women who were under 65 in 1960 will have entered into the retirement years by 1970 with at least 20 years of employment behind them. They will be retiring at progressively higher Social Security rates and an increasing number will be drawing private pensions. Home ownership will be more prevalent among them and a larger proportion than ever will carry health insurance into retirement because of programs set up by their employers.

It should be clear to the most blinded Medicare proponent that the medical cost problem of the aged is a progressively shrinking problem. It promises to be transitional, not perpetual, and therefore does not call for a solution — like the Social Security approach — which is designed to operate in perpetuity.

With our present program of Social Security cash benefits facing a very severe test during this decade of the 1960's, it is difficult to understand the reasoning of those who would permanently saddle the additional cost of Medicare onto Social Security. Maximum Social Security taxes on each worker and his employer will rise from $150 this year to $222 in 1968, with no corresponding increase in benefits. All of the money raised through higher taxes is needed to pay benefits already promised by Congress to the many millions of aged, their dependents and their young survivors who are coming on the rolls in the future. There will be nothing left over to make benefits bigger or easier to get — or to add on new benefits — not a thin dime.

I am not an overly suspicious man, but in view of all the facts I have laid before you this evening, I find myself wondering why the Administration is so adamant about establishing the principle of Social Security paying for services. Are the advocates of Medicare as humanitarian as they contend? Or is there something up the magician's sleeve.

Looking back over the record of the Senate debate last July, we find the Junior Senator from Tennessee acknowledging that he viewed the Social Security health insurance proposal as "only a beginning." And we find Walter Reuther, President of the United Auto Workers, saying that the real objective is to get the principle of Social Security paying for services and then to build on that principle. So we see that the proposal to add just one-quarter of one per cent to our Social Security tax is just a starter — a sort of foot in the door.

Perhaps the real truth is that this legislation has been designed to create pressures for future expansion — first to cover other kinds of services and then to cover the entire population, not just those over 65.

Let me explain: We know, for example, that many older persons have less need for hospital care than for doctor's visits, dental care, and drugs and medicines administered outside the hospitals. What do you suppose will happen when they find out that Medicare won't really help them because it ignores three-fourths of their needs?

Under the Social Security approach, age is the sole criterion for Medicare eligibility. A man of 65 who is eligible for Social Security cash benefits but who isn't getting them because he is working full time can have his health care bills paid. But another man, 64 years of age, working full time for the same company at a lower salary is denied help because he isn't old enough. And what about the 62 and 63 year old widows living on small Social Security cash benefits? Or permanently disabled persons under 65 who are unable to work? Don't they need their health bills paid for more than the 65-year-old who can work full time?

With so many built-in inequities, it doesn't tax the imagination to see that Congress would soon be under pressure to expand Medicare to everyone covered by Social Security, regardless of age.

In the meantime every young married family, raising children, paying for their homes, educating their sons and daughters, will be taxed to provide nothing for themselves — benefits for those over 65 be they millionaires, paupers, prosperous farmers,

doctors, lawyers, in their prime earning years — what a cruel, unjust, foreign, socialistic mess this is.

Let's ask ourselves if this is what we want in this country. President Kennedy said in his Madison Square Garden speech in New York City last May that "we are behind every country, pretty nearly, in Europe in this matter of medical care for our citizens."

As much as I want to see harmony between business and government, I strenuously disagree with the President. To the absolute contrary I believe we are ahead of all other countries. The reason we are ahead, the reason why we do not and will not have a universal compulsory program in this country is because private enterprise, private medicine has successfully filled the void. The record shows that we are continuously striving to find new and better ways to meet the medical needs of our citizens. The governments had to step in in those foreign countries because practically nothing had been done by private enterprise.

Let's remember that it wasn't the government that made this country economically strong. It was a people gifted with the courage and the ability to do for themselves. It's a strange irony that a people who just a month ago faced calmly and steadfastly up to the imminent peril of nuclear war are being told today that they can't take care of themselves.

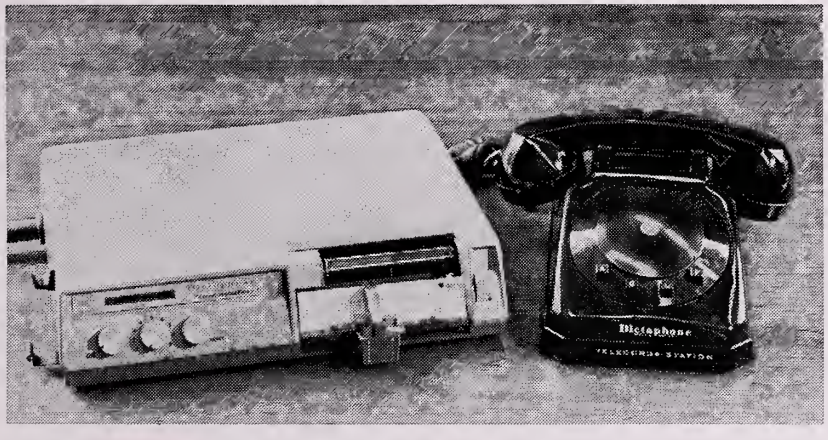
The United States is the only country left where there still flourishes the opportunity to experiment, to innovate, and to develop its own voluntary solutions in the medical care field.

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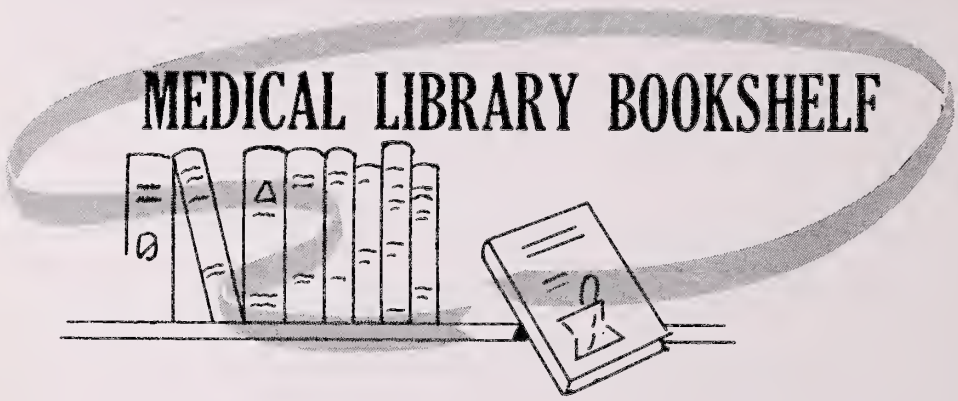


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MODERN HEART SURGERY

A recent gift book sent to the South Dakota Journal of Medicine and Pharmacy for reviewing is the **Risk Takers** by Hugh McLeave. Holt, Rinehart and Winston, 1962.

Hugh McLeave is the scientific and medical reporter for the News Chronicle and Daily Mail in London. The book is designed for the layman on the popular subject of heart surgery. It is of value also to those in the medical field for history of the pioneers who laid the groundwork and made the accomplishments of today possible.

The following are some of the interesting facts included in this well written chronicle of the achievements of heart surgery.

As early as 1896 Dr. Ludwig Rehn, Head of the Surgical Department of the City Hospital in Frankfurt, Germany, performed successful heart surgery on a 22 year old patient with a knife wound, taking 3 stitches in his heart.

In 1920 Dr. Henry Souttar, consultant surgeon to the London Hospital, invented the Souttar's Eyeless Needle and performed the first successful operation for mitral stenosis, an account of which is published in the **British Medical Journal,** 1925, p. 603-606. In **Lancet** v. 201, July 1921, p. 133 there is a brief account written by Dr. Souttar with a diagram of an improved surgical needle with a tubular end for insertion of "London Hospital" catgut.

Dr. Werner Forssman in 1929 passed a catheter tube through his own vein and into the right upper chamber of the heart and published a paper with 2 x-rays in **Klinische Wochenschrift,** which obscure paper led the way to more accurate diagnosis of cardiac conditions in the 1940's and 1950's.

Others were Dr. Ferdinand Sauerbruch who is credited with the first successful case of surgery on heart aneurysm; Dr. Robert E. Gross of Harvard Medical School who operated successfully on an inborn defect, Patent Ductus Arteriosus, and Dr. Clarence Crafoord of the Surgical Clinic of Sabbatsberg Hospital in Stockholm for his operation on coarctation of the aorta.

Cooperation between physician and surgeon was established in the Blalock-Taussig operation, the classic description of which was published in the **Journal of the American Medical Association,** v. 128, 1945 p. 189, entitled The Surgical Treatment of Malformations of the Heart in which there is Pulmonary Stenosis or Pulmonary Atresia. Details of the operation are given with illustrations.

Later Dr. Willis Potts of Chicago University devised a method and an instrument for by-passing blood from the main channel into the lung artery. Both operations have saved the lives of thousands of children including Blue Babies.

In Great Britain Dr. Russell Brock at Guy's Hospital and Dr. T. Holmes Sellors of Middlesex Hospital performed operations for pulmonary valvulotomy for relief of congenital pulmonary stenosis in which the pulmonary valves were divided to allow more blood in the lungs. Dr. Brock's results were published in the **British Medical Journal** v. 1, June 12, 1948 p. 1121-1126 and Dr. Sellors that same year in **Lancet** 1, June 26, 1948 p. 988-989.

In America the mitral valve was successfully operated on by Dr. Charles Bailey, Professor of Surgery at Hahnemann Medical College. In 1953 Dr. John Gibbon of Jefferson Medical College invented the Heart-Lung machine. Although an operation failure stopped its use the Mayo Clinic in 1955 found the machine flawless and used it with great success.

The use of drugs including curare, antibiotics, the catheter for diagnosis and soundings, the electrocardiograph, all increased the success of heart surgery.

Famous teams such as the one in Minnesota with Dr. C. Walton Lillehei as the head revolutionized heart surgery with the Gibbon and Lillehei machines. A team of surgeons in Cleveland used the Kolffs heart-lung machine effectively with the Melrose technique of open heart surgery. They were invited to Moscow where they amazed the Russians with their accomplishments.

The use of hypothermia, artificial valves, PTFE plastic for arteries and spare part surgery are recent advances. The author in a final chapter suggests that in ten years' time a worn-out heart may be replaced with a new artificial one.

This book of enjoyable and instructive reading will give the reader interesting information about the possibilities and achievements of heart surgery of the past and present. It has been endorsed by such leading heart specialists as Dr. John H. Gibbon, Head of the Dept. of Surgery, Jefferson Medical College and Dr. Robert S. Litwak, Chief of the Division of Cardio-thoracic surgery of Mount Sinai Hospital.

Esther Howard
Medical Librarian

WARTS

(Continued from Page 24)

fast cauterizing procedures. Curettage and/or electrosurgical destruction are employed frequently and successfully.

However, the most painless and frequently very successful therapeutic approach to plantar warts is by means of x-ray therapy.

X-ray therapy of warts in the hands of somebody experienced in its use, is a valuable tool in the treatment of selected warts. This is especially true with respect to plantar warts, single or multiple.

But it is also useful in the treatment of large warts on the hands, may they be single or restricted to just a few.

It is especially useful in the treatment of selected cases where any scarring or pain has to be avoided, like on the hands of a musician, actor, or of an occasional very fussy individual.

The advantage of this type of treatment is obvious. There is no pain whatsoever, the method is successful in about 70% of the cases, maybe more, the warts disappear, shrinking away without leaving a trace in about three weeks.

The very worst that can happen is that the treatment may not be successful, in which case other measures still can be employed successfully, to eradicate the wart.

X-ray therapy recommends itself, especially in the treatment of plantar warts, as it usually relieves the often very considerable pain present with these warts, in a matter of about ten days.

Of course one has to be aware of the fact that some of the warts will not respond to x-ray therapy. One has to be aware of the safe limits beyond which no further x-ray therapy may be given. One has to be adamant in the refusal to give any further x-ray therapy if the amount of x-ray therapy administered has reached such limits.

If such precautions are being observed, x-ray therapy is safe and useful in the treatment of plantar and other selected warts.

On the other hand, if these and all other necessary precautions of a technical nature are not scrupulously observed one may invite disaster in the form of a chronic x-ray burn and ulceration, which may take major plastic surgery to correct.

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Pop's Proverbs

Be careful of what you say — it may not meet your wife's approval.

NEWS NOTE

Dr. Albin J. Janusz, formerly located at Freeport, Illinois, has joined the staff of the Aberdeen Medical Center. Dr. Janusz is a graduate of the University of Illinois and is a Diplomate of the American Board of Surgery.

* * *

Edward G. Huppler, M.D., of Watertown, has been advised that he has been approved for Fellowship in the American College of Chest Physicians and will receive a certificate of Fellowship at the annual meeting of the American College of Chest Physicians in Atlantic City, June 13-17th.

* * *

The South Dakota Medical Assistants Society met in Mitchell on May 17th and 18th.

FIVE DAKOTANS ATTEND AMPAC CHICAGO WORKSHOP

Five South Dakotans sat in on sessions at the AMPAC workshop in Chicago on May 18th and 19th. Dr. T. J. Wrage, secretary of the South Dakota Physicians Committee headed the delegation which also included Dr. Robert Hayes of Winner, Mrs. Gladys Wold of Madison, John Zimmer of Parker and John Foster of Sioux Falls.

The meeting was highlighted by talks by Leonard Hall and James F. Murray, Jr.

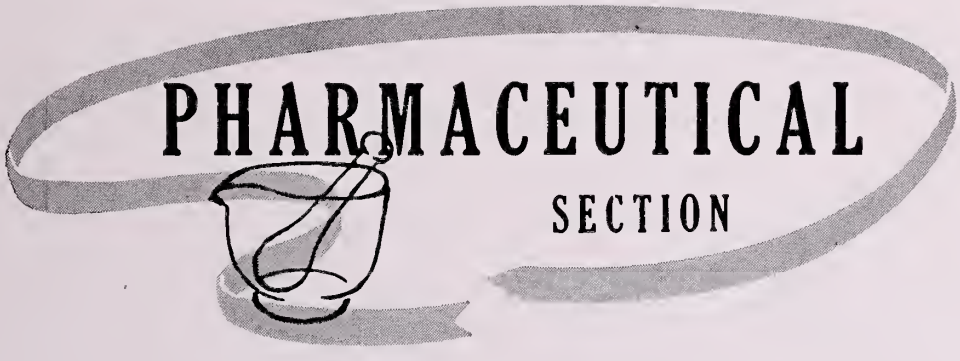
* * *

SOUTH DAKOTA GRADUATE ELECTED PRESIDENT OF SAMA

A recent graduate of the Medical School at the University of South Dakota has achieved national distinction by his recent election to the presidency of the Student American Medical Association. Mr. Robert Voy of Dell Rapids, South Dakota, graduated from medical school at Vermillion in 1962 and is just completing his junior year in medicine at the University of Oregon. While at the University, Robert was an honor student and served as president of the South Dakota Chapter of the Student American Medical Association.

There is some distinction in his being honored in this manner since he represented the second South Dakota graduate in a period of ten years to be elected president of this national organization. The first president of the Student American Medical Association was another University graduate, David Buchanan of Huron, who is now practicing medicine in Huron with his father, Dr. R. A. Buchanan.

The Student American Medical Association is made up of chapters at each of some 75 medical schools throughout the country and has been an organization which has directed itself to a consideration and solution of many of the problems which confront the medical student.



GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota



ABUSE CHARACTERISTICS OF PSYCHOTOXIC DRUGS*

1. Opiates, Morphine and Morphinelike Analgesics

Morphine is the predominant active principle of opium. Its primary value in medicine relates to its pain-relieving properties. These are effected largely by two mechanisms: The modification of the perceptual pattern of pain without its complete obliteration ("I can feel the pain, but it doesn't hurt") and secondly, relief of the anxiety associated with pain or the anticipation of pain. In some individuals, morphine may also produce a true euphoria, an elevation of mood over and above the relief of discomfort. No other known class of drugs possesses these properties which make them indispensable in the practice of medicine. Nearly every human in severe pain welcomes their effects. Some people, for reasons which are not well understood, prefer the mental and physical conditions created by these drugs to a more conventional existence in society. Their desire for relief of presumed mental "pain" is so intense that acquisition of the drug and its regular uninterrupted use become motivating forces in their existence. This type of chronic use produces the classical mental and physical responses which are designated by the term "addiction": Psychological dependence, tolerance, and physical dependence. Morphine is, therefore, not only the prototype of all addictive drugs, but creates all mental or biological responses associated with the term addiction.

The clinical effects of chronic morphine administration are typified by somnolence alternating with periods of wakefulness, constipation, pupillary constriction, marked loss of libido and, in women, cessation of menstruation. Slowing of pulse rate, depression of respiration, and a decrease in blood pressure occur in the nonaddict, but disappear with tolerance. Emaciation, if present, is secondary to malnutrition resulting from the user's disinterest in anything except the satisfaction of his addiction.

When narcotics such as morphine are withheld from a physically dependent person, a well-defined withdrawal syndrome results. This includes yawning, tearing, sweating, pupillary dilatation, abdominal cramps, muscle aches, and hot and cold flashes. The peak reaction is reached after 48 hours and includes violent vomiting and diarrhea, fever, and marked hyperactivity. Symptoms start

* Excerpted from Appendix One, Report of an Ad Hoc Panel on Drug Abuse, The White House, Washington, D. C.

to decline about the 72nd hour, and most objective signs are gone usually in 7 to 10 days.

Subjective symptoms may remain, however, for as long as 6 months, particularly when recalled by psychic stress or exposure to (though not necessarily administration of) more narcotic. The Panel has been unable to find any studies which demonstrate conclusively whether these symptoms are psychogenic or are, in fact, manifestations of a residual physiologic or pathologic change. The prolonged withdrawal necessary for babies born of addicted mothers indicates that more than suggestibility may be involved in the symptoms reported by the addict long after his detoxication, and for which he again feels the need of relief through his well-established pattern of drug administration.

(a) Morphine

Illicit abuse in the United States is associated largely with diversion of the drug from legitimate channels of distribution available to the physician and others legally qualified to prescribe narcotics. This diversion is accomplished by a variety of methods, including thefts from doctors' offices and automobiles, forging of prescriptions, and thefts from stored supplies. An unknown number of individuals are supplied by physicians. Because the drug obtained by any of these means is pure and hence more potent, the degree of physical dependence produced is usually much greater than that induced by the dilute heroin presently obtained in the illicit market.

(b) Heroin

When the term addiction is used without qualifications, the tacit assumption is that heroin is the drug in question. Heroin (diacetyl morphine) is a derivative of morphine, and may be prepared quite simply by treatment of that substance with acetic anhydride. This method produces a gram-for-gram yield of heroin. Since heroin is approximately three times as potent as morphine itself, the chemist can, in biologic terms, extend the morphine supply by this method.

A great deal of fiction has developed concerning heroin, beginning with its introduction as a nonaddicting substitute for morphine. A seasoned addict can determine some difference when the drug is given intravenously in comparison with morphine, but for practical purposes the pharmacological effects of the two drugs are indistinguishable, although heroin is somewhat more rapid in its action. In spite of this, heroin, more than any other drug, has come to be specially feared because of the unique powers of moral depredation and physical harm that are attributed to it. Its use, even for therapeutic purposes, is prescribed in the United States and many other countries. An argument can be made for its prohibition on the grounds that equally effective drugs are available. But the impression that heroin has properties or actions which make it either more harmful or significantly more addictive than morphine should be corrected.

Heroin has been the principal item of illicit drug commerce in the United States. Today, however, the addict is rarely able to purchase a pure sample. Stringent control measures have reduced the supply so drastically that the abuse pattern of this drug has changed. The limited amounts available on the illicit market are cut with milk sugar, talcum powder, or other diluents, so that most samples seized contain only 3 to 5 percent of the drug.

As a result, the institutions visited by the Panel have not admitted an addict with a severe physical dependence upon heroin for more than 2 years. In many instances, especially with juveniles, heroin abuse involves only an occasional injection on a "spree" basis without creation of tolerance or physical dependence. Practically all heroin is now taken intravenously in order to obtain the maximum effect from the small doses available, and to produce the "thrill" so desired by the heroin addict.

(c) Dihydromorphinone; hydromorphone (Dilaudid)

This derivative of morphine is five times as potent as the parent compound. It was introduced into medicine as a nonaddicting morphine substitute, a fallacy soon dispelled. Some medical misuse has followed its introduction, but this drug has never been extensively abused and there is little illicit distribution.

(d) Codeine; dihydrocodeinone (Hycodan, Dicodid); and dihydrohydroxycodeinone (Percodan)

Codeine is monomethylmorphine. It occurs naturally in opium in small quantities, but that available to meet medical demand is prepared by a simple methylation of morphine. The extra chemical step and lower effectiveness per milligram compared with morphine make codeine more expensive per unit dose for some purposes. Codeine is a mild analgesic and a principal drug in the treatment of cough. It will substitute for morphine if sufficiently large doses are used, but it and its preparations have a very low abuse potential. This has been recognized throughout the world and has resulted in the establishment under international controls of the group II category of drugs in 1931. Drugs in this category were permitted to be freed at the national retail level from some of the restrictions applied to more potent compounds. In the United States, however, codeine is available only on narcotics prescription, but its liquid preparations intended for the treatment of cough (such as the well-known elixir of terpin hydrate and codeine or other flavored cough syrups), containing not more than 64.8 mg. of codeine per fluid or avoirdupois ounce are available in limited quantity without prescription. Primary codeine addiction is rare, as is the substitution of codeine for another opiate to maintain addiction. The liquid preparations are abused occasionally, but are of little significance with respect to the general drug abuse problem.

Hydrocodone (Hycodan, Dicodid) and oxycodone (Percodan), are related to codeine chemically, but do not occur naturally. They are prepared by a sequence of chemical transformations from thebaine, another opium alkaloid. They are more potent than codeine as analgesics (pain relief) and antitussives (cough relief), as substitutes for morphine or other opiates in an addicted individual, and as causative agents in the development of tolerance and physical dependence under conditions of primary chronic administration. Both drugs in their pure form are under full narcotics control; some of their compounds, limited in the quantity of opiate ingredient and containing other agents, are available for oral prescription. The abuse liability of these solid preparations is currently being reviewed. Liquid preparations of hydrocodone, containing not more than one-sixth grain of hydrocodone per fluid ounce, were available like similar codeine preparations through over-the-counter sale for cough relief. This exempt status has been revoked due to outbreaks of abuse of these preparations in a number of areas.

Much apprehension has been created by reports that teenagers drink cough preparations along with beer or other alcohol-containing drug mixtures. Since some of these cough remedies contain as much as 42 percent alcohol, their appeal and the effects of their ingestion may be due to the alcohol effect as well as to that of the opiate ingredient. The degree of dependence produced, even with the consumption of large amounts of these cough preparations, is least with codeine and is in any case minimal. We can find no evidence to warrant change in the present status of codeine, hydrocodone, oxycodone, and their preparations relative to provisions for narcotics control of more severity for codeine or less severity for the others.

(e) Opium preparations

Another exempt preparation available in limited quantity is paregoric or camphorated opium tincture. It contains 35 to 45 mg. of morphine in 100 cc. of alcoholic solution. Paregoric addicts travel from drugstore to drugstore to obtain the small quantity available without prescription and at the end of the day combine their purchases to obtain a narcotic effect. Although some paregoric users boil off the alcohol and inject the residue intravenously, the drug is generally taken orally and passes through the liver before it reaches the blood-stream, thus inactivating a large fraction before it can reach the central nervous system. Thus, the effects are not profound and appeal primarily to the "down and outers."

(f) Synthetic analgesics with morphinelike effects

The drug of this class which has been most abused is meperidine (Demerol). Unfortunately, this compound has gained a false reputation of being less capable of producing

physical dependence than morphine. This misconception is held by many of those who have legal access to it, e.g., physicians, dentists, and nurses. As a result, many individuals associated with the health professions have become dependent upon this drug. In a considerable number of instances poorly informed doctors have created dependence in patients by repeated use of large doses over a long period of time. Practically all of the drug is obtained through legal channels. There is some diversion, forging of prescriptions, and theft, but surprisingly little is available illicitly. The solution to this particular problem resides in education of the physician to the potential hazards of the drug.

The abuse of other synthetic substances is not serious in the United States. Only a few cases of methadone addiction have been reported, and in most instances where addiction occurs it is related to its therapeutic use rather than its availability through illicit channels.

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THE FOOD AND DRUG ADMINISTRATION'S VIEW OF INVESTIGATIONAL DRUGS*

by

Earl L. Meyers, Ph.D.**
Washington, D. C.

It is indeed a pleasure to join the distinguished speakers on this panel and participate in this symposium on investigational drugs. It is timely to take a new look at the subject since the recent enactment of the Kefauver-Harris Amendments to the Federal Food, Drug, and Cosmetic Act and the promulgation of the investigational drug regulations which became effective February 7, 1963. At no time in this country's history has the private citizen been more interested, more concerned, and more inquiring about drugs and their relation to his health.

Largely due to the tremendous strides in the general field of chemistry over the past two decades, there has been a parallel surge in the pharmaceutical industry, resulting in the greatest development of new drugs ever experienced in any like period of medical history. The increased factory inspection authority and possibly some of the other provisions added to the Food, Drug, and Cosmetic Act by the amendments were undoubtedly catalyzed by the thalidomide disaster. The need for such controls had, however, been recognized and plans for meeting this need had been under study for a considerable period prior to this occurrence. The investigational drug regulations represent a crystallization of many years of Food and Drug Administration experience and virtually all of the new concepts contained therein were developed before the thalidomide case. Likewise, the new legislation is mainly derived from more than two years of congressional hearings and legislative recommendations developed before the thalidomide case. Had the same changes been accomplished gradually, their impact would seem less drastic.

It is obvious that the many scientific advancements made in recent years have made the development of new drugs an ever-changing process. So are the techniques, methods of approach, and scientific developments that may reasonably be expected to be performed to demonstrate safety, and now effectiveness, and hence to be reflected in a new drug application. It should be apparent then that the

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*An address delivered at the Annual Pharmacy Congress, St. John's University, New York, N.Y., April 18, 1963.

**Chief, Controls Evaluation Branch, Division of New Drugs, Bureau of Medicine, U. S. Department of Health, Education and Welfare.

amount and type of data that were considered sufficient 20 or even 10 or 5 years ago to support a new drug application might now be deemed inadequate. In this regard we can no more be static in our requirements than is the manufacturer in his application of new methods to his drug development programs.

Let us first consider the principles under which we now are operating the new drug provisions of the Food, Drug, and Cosmetic Act.

One of the major changes brought about by the new legislation is in the definition of a "new drug." "Effective" has been added to the definition. The term "new drug" now means any drug which is not generally recognized as safe and effective by experts qualified to evaluate the safety and effectiveness of drugs when used under the conditions prescribed, recommended, or suggested in its labeling, or which is recognized as safe and effective as a result of investigations but has not been used for a material time or to a material extent under such conditions.

The Federal Food, Drug, and Cosmetic Act of 1938 prohibited the shipment of a new drug in interstate commerce until the distributor had obtained an effective new drug application for it. The purpose of the preclearance for safety has been to obtain advance proof that the drug would be properly prepared, adequately labeled, and safe for use under the conditions prescribed, recommended, or suggested in its labeling. We have invariably considered efficacy in connection with safety in clearing new drugs when they were for a progressive or life-threatening condition or when they had a significant toxic potential for harm to the patient. Safety is a relative matter with drugs, and effectiveness has been treated as the balancing factor in determining whether a new drug could be permitted to be marketed. But the new drug provisions did not authorize us to control exaggerated claims or to exclude from the market worthless but essentially innocuous products.

The Kefauver-Harris Amendments of October 10, 1962, require an approved application not only for the safety of the drug, as previously, but also for effectiveness. New drugs may be excluded from the market or removed from the market when there is a lack of substantial evidence that they will do what is claimed in their labeling. Substantial evidence of effectiveness means adequate and well-controlled investigations, including clinical studies, on the basis of which it can reasonably and responsibly be concluded that the drug will have the effects claimed. Now, manufacturers of new drugs will therefore need to demonstrate their effectiveness as well as safety for the conditions prescribed, recommended, or suggested in their labeling.

For drugs now having an effective new drug application, applicants generally have a two-year transitional period from October 1962, before such drugs could be ordered off the market on the sole ground of lack of substantial evidence of effectiveness for claims made for them by the previously cleared labeling. In this connection applicants should review their labeling claims to determine whether there is substantial evidence in the application to support them. It is recommended that any previously unreported evidence pertinent to the effectiveness of the drug should be submitted at an early date. Unsubstantiated claims for effectiveness can be eliminated by supplementing the new drug application to provide for labeling without these claims, or marketing of the drug may be discontinued with resumption of marketing under the provisions of an approved supplemental application supported by substantial evidence of effectiveness.

In order to obtain data to show safety and effectiveness the drug must be distributed to investigators. Accordingly, the statute includes a provision which allows such distribution and authorizes the Secretary to issue regulations in this connection. Regulations under which we had been operating required only that a new drug distributed for investigational use be labeled "Caution: New Drug — Limited by Federal (or United States) law to investigational use," and that the sponsor before shipping such drug obtain from the investigator a written commitment that he would use the drug only for investigation and that he had adequate facilities for this purpose. These statements and records of shipments were subject to inspection by the Food and Drug Administration.

Experience showed that stronger regulations were needed, fortified with concepts

designed to maintain better control over the distribution of drugs not yet proven safe and to guard against abuses which occurred under the existing rules. On August 10, 1962, we published proposed regulations covering these new concepts and designed to correct the deficiencies. Our proposals were subjected to a great deal of helpful and constructive comment by the scientific community. Their objective was rather universally accepted but exception was taken to some of the procedures and protocols. The recently enacted drug amendments require that several specific factors be considered before we exempt new drugs for investigational use. After careful review of all of the submitted comments and after a number of meetings with groups of scientists and others, the final regulations were published on January 8, 1963. They became effective on February 7, 1963.

The intent both of the regulations and of the law is to ensure, among other things, that the pharmaceutical manufacturer who wishes to have his product tested on man will conduct adequate preliminary studies to justify clinical testing, and will make the results of these tests fully available to the expert investigator and to the Government before the drug is administered to man. The manufacturer will have to develop a scientifically sound program for the clinical tests he proposes. He will have to see to it that the new drug is turned over to qualified investigators who will test it on patients under their personal supervision or under the supervision of qualified investigators responsible to them.

It is important to emphasize that a new drug has a different meaning than before passage of the Kefauver-Harris Amendments. In other words, the investigational drug requirements apply to the clinical study of any drug not generally recognized as effective as well as safe for the intended use.

Let us consider some of the more important provisions of the investigational drug regulations. Prior to distribution of a new drug for clinical testing in man the sponsor of the investigation is required to submit to the Food and Drug Administration certain specified information as part of a "Notice of Claimed Investigational Exemption for a New Drug." This includes:

1. **The name, dosage form,** components, quantitative composition, and the chemical structure, if known, of the new drug substance.

2. **A description of the source and preparation** of any new drug substances and the methods used to ensure the identity and uniformity of the new drug. The complex chemistry involved in the synthesis of new drugs, and the information derived from newer techniques in analytical procedures indicate the need for a more detailed description of the synthesis and the specifications for the new drug substance, and reliable tests for the drug as used in its investigational dosage form. These should be incorporated as part of the necessary information in a sponsor's statement.

3. **The methods, facilities, and controls** used for the manufacturing, processing, and packing of the new drug to establish and maintain appropriate standards of identity, strength, quality, and purity for safety and to give significance to the clinical investigations made with the drug.

The new drug substance in a dosage form of a drug is probably not the sole determinant of its pharmacological effectiveness. The physiological response may be a function of the formulation of the dosage form as well as the new drug component. The rate at which the amount of the new drug component in the dosage form is physiologically available to the patient upon administration is an important consideration. We have encountered cases of varied clinical response between batches of the same pharmaceutical formulation. Additional study has indicated that differences in physical and chemical properties were caused, among other things, by differences in physical properties of the raw materials such as crystalline or amorphous form and particle size, conditions encountered during processing, and contact of the components in the dosage form resulting in complexing, binding, and adsorption. Therefore, early consideration of these factors during the investigational stages of the drug is necessary.

It also becomes important to establish the reproducibility of the dosage form of a drug from batch to batch if the clinical studies are

not to be biased by an unknown variable. All batches must be uniform in identity, strength, and quality so that the patient receives what he's supposed to be getting. We have only to recall recent observations that there exists a considerable lack of homogeneity between tablets from the same batch to realize the importance of early work necessary to produce a uniform dosage form of the drug from batch to batch.

The investigational evidence that a drug is safe and effective in use does not necessarily establish that its deterioration products are safe and effective. Evidence establishing the safety and effectiveness of one or more batches of a new drug under investigation has no significance with respect to the safety of subsequent batches of the drug unless they can be shown to be the same as to identity, strength, quality, and purity as the batches studied. The requirement in the law and regulations that the methods, facilities, and controls employed are adequate to preserve the characteristics of a new drug necessitate study of the stability of the preparation during the investigational stage.

4. **Adequate information on preclinical testing** to show that it is reasonably safe to initiate the proposed clinical studies. This requirement arises from the obvious need to conduct adequate testing on animals before starting human trials. The sponsor's submission should contain detailed data derived from appropriate animal experiments in which the methods used and the results obtained are clearly set forth. This usually means pharmacologic studies in animals. The kind and the amount of information required will depend on several factors, such as the nature of the drug and its indication, and must be determined individually for each new drug.

5. **The labeling or other information** to be furnished to investigators. The clinical investigator must have sound information as to prior tests to make his decisions about dosages to employ and hazards and side effects to look for in clinical studies.

6. **The name and a summary of the training and experience** of each investigator or expert. Neither the 1938 law, the new legislation, nor the investigational drug regulations define who is an "expert qualified by scientific training and experience to investigate the safety of drugs." We believe that at least in the early phases of clinical investigation of a novel drug it refers to physicians who have experience in drug investigation and are specialists in the field applicable to the specific drug. Furthermore, they should have adequate facilities for investigation with respect to patients, clinical laboratory services, and time to give attention to such studies. This usually does not apply to the busy general practitioner. Initially, the anticipated effects of the sections of the regulations dealing with the qualifications of experts are that sponsors of investigations will obtain and more carefully consider the qualifications of investigators to do what is required with safety and in a manner that will contribute to an evaluation of the drug. Clearly, a clinical investigator should be qualified, should maintain and make available required records and reports, and should use sound scientific judgment in testing a new drug. The information with respect to the qualifications of investigators will be helpful to the Food and Drug Administration in evaluation of their reports in new drug applications.

7. **An outline of the planned investigations,** which may be submitted by phases. Phases 1 and 2 cover the clinical pharmacology with administration of the drug in a closely controlled scientific environment to a limited number of patients and under professional controls which assume a large measure of safety. Phase 3 covers the clinical trial in which the drug is used with a larger group of patients by different physicians following substantially the same investigational procedures. Reasonable flexibility of a plan of investigation is provided for. An investigator may pursue promising leads that may emerge in the early stages of his investigations, and he may modify experimental design on the basis of experience, advising the sponsor in progress reports. During clinical studies, reasonable variations of investigators, patients, and design are possible.

8. **If the drug is sold,** a full explanation of why sale is necessary. In certain instances there may be justification for charging for an investigational drug. However, we believe we should have the facts so that we may

reach our own decision as to whether sale of the drug represents premature commercialization.

The regulations also provide that neither the sponsor nor any person acting on his behalf shall disseminate any promotional material representing the investigational drug to be safe or useful for the purposes for which it is under investigation. In consideration of this point in the regulations fear was expressed that this would prevent the presentation or publication of scientific papers or reporting of such in the lay press. This is definitely not its intention. Nothing here would foreclose an exchange of scientific views about a new drug by scientists. Nor would anything here interfere with bona fide science reporting.

The sponsor also is required to inform all investigators and the Food and Drug Administration of findings which suggest any hazard in use of the drug, and to discontinue the investigation and to recall outstanding stocks of the drug if the investigations reveal facts showing that there is substantial doubt they may be continued safely. The prompt dissemination of findings of adverse effects may facilitate their early evaluation which would not otherwise occur if they remained as isolated observations, possibly without identification of the drug as a causative agent.

It should also be noted that when the sponsor files with Food and Drug Administration the notice of claimed investigational exemption for a new drug, he and the investigators are free to proceed without notification. If, however, there is failure to comply with the conditions of the exemptions and failure to correct the situation on notification of it, the Commissioner shall notify the sponsor of the termination of the exemption.

Each investigator involved in clinical pharmacology and in clinical trials is required to submit the following information to the sponsor of the investigation:

1. A statement of his education, experience, and the facilities he will employ in the investigation.

2. An outline of the plan for his investigation.

3. Statements showing he understands the conditions governing the use of investigational drugs, including the maintenance of records, the submission of reports to the sponsor, and making his records available for Government inspection.

Some investigators have felt no obligation to submit reports and some sponsors have exerted little effort to obtain them. Making the submission of reports a condition for receiving the drug should go far in correcting this. We have received a number of comments to the effect that the burden of producing required records and reports will discourage some physicians from participating in investigations. This may well happen in some instances. However, the failure to record and report results of the investigational use of drugs for the benefit of the medical community may lead to a repetition of drug injuries and deaths that may otherwise be avoided.

We have also received comments with respect to the provision which allows inspection of the records of the investigators in that this may encroach on the physician-patient relationship. There is no intent to require individual patient identification ordinarily. Such information may be considered necessary, however, in certain instances where there is reason to believe that the records do not represent actual cases studied or do not represent actual results obtained or where the records of particular patients indicate that a more detailed study is required.

Of particular interest is the patient consent provision included in the new amendments to the Act. It is required that the sponsor of the investigation obtain a certification from an investigator that he will inform any human beings or their representatives (including controls) that the drug is being used for investigational purposes and obtain their consent for such use except where the investigator deems it not feasible or, in his professional judgment, contrary to the best interests of such human beings. This requirement reflects the long-standing belief by our society and others that patients who are being used as experimental subjects should first give their consent.

We received a number of comments with respect to the special status of radioactive

new drugs for investigational use. Pending further consideration, these drugs are exempt from the investigational drug regulations if they are shipped in accordance with current regulations of the Atomic Energy Commission.

The investigational drug regulations contain only a brief statement on new veterinary drugs for investigational use pending issuance of specific regulations. The regulations provide for use of drugs for tests on animals. However, meat, milk, and eggs derived from treated food animals may not be used for food purposes until the Food and Drug Administration allows such use on a showing that drug residues do not cause the food to be unsafe.

Final regulations are not as immutable as the word "final" may imply to the nonbureaucrat. The investigational drug regulations can be changed when the need for change becomes apparent. The medical profession, pharmacists, pharmaceutical manufacturers, and any others who are interested should feel free to suggest improvements at any time. And where such suggestions are consistent with our joint basic responsibility to see that the rights of patients are fully safeguarded in a testing program, we will propose appropriate changes. Such proposals would be subject to comment by interested persons just as the current regulations were.

We anticipate that the sponsor's statement on investigational antibiotic drugs will be processed by the same scientists as any other investigational drug. All of the scientific and technical resources of the Food and Drug Administration will be employed in the evaluation of the sponsor's notice and of the progress reports.

Where drugs were under clinical trial on man on or after August 10, 1962, the sponsor was required to submit a list of such investigational drugs by March 9, 1963. We have received lists containing the names of approximately 2,500 drugs which were under investigation. The sponsor is required to submit to the Food and Drug Administration by June 7, 1963, the completed "Notice of Claimed Investigational Exemption for a New Drug," a new drug application, or a statement of discontinuance of clinical trials for each of these listed drugs.

If a sponsor proposes to continue the clinical investigation of his drug after he submits a new drug application, it will be necessary for him to submit a completed "Notice of Claimed Investigational Exemption for a New Drug," or to furnish all the information required by such "Notice" covering the continuation of the clinical trials as part of the new drug application. Any information already a part of the new drug application may be incorporated by reference in a sponsor's statement.

After an application is approved, it may be desirable to initiate additional investigations with the drug. If such investigations are limited to use of the drug under conditions covered by the approved labeling as to indications, dosages, duration, etc., then no advance notification to the Food and Drug Administration is required. An example of such studies might be double blind comparison of the approved dosage form of the new drug with a placebo and other active drugs to develop additional information with respect to effectiveness. Although no prior notification is required, the results of such studies should be reported to the Food and Drug Administration under the records and reports requirement for approved drugs and antibiotics contained in the Kefauver-Harris Amendments.

However, if the clinical investigations involve use of the drug for purposes or under conditions as to indications, dosage, or duration of use differing from the approved labeling, prior to starting clinical study it should be covered by submission to the Food and Drug Administration of the claimed investigation exemption to the extent applicable. Data required by the sponsor's statement may be incorporated by reference to the approved new drug application.

The marvelous advances that have been made in recent years by most firms to improve the new drug supply must be carried forward. Firms that carry out these investigational procedures in their own facilities must assure themselves of the competence and reliability of scientific personnel in charge of this work. They must further provide the scientists with complete and up-to-date equipment, adequate to maintain the identity, strength, quality, and purity of such

new drugs. Those firms which rely upon independent laboratories must assure themselves that the laboratory they choose is reliably fulfilling the tasks it has agreed to perform.

No doubt every one of us will agree that the past year has marked the start of a new and challenging period for the drug industry. A combination of circumstances has aroused the public interest in knowing more about the drug business. There is no doubt in my mind that the operations of the Food and Drug Administration will be subjected to the same close scrutiny as the operations of the drug industry.

The Government regulatory official must always remember that the work he is doing and the decisions he is making are subject at any time to public review. And it may well be that the only way the drug industry is going to keep the confidence of the American public in its products will be for it to live in a goldfish bowl, too.

Whenever in the past there have been new controls proposed for the drug industry and for a time after new legislative controls came into force there were numerous voices heard decrying the ruin of this industry. It is no different at this time. It should be emphasized that the investigational drug regulations are designed to eliminate all unnecessary risks to the public that may arise from the development of new drugs and at the same time to impose only those restrictions on the conduct of investigational procedures necessary to accomplish this.

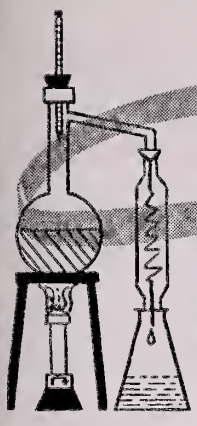
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The regulations established no criteria as to what constitutes adequate preclinical investigation to justify tests in man. We will deal with gross inadequacies initially. We propose to utilize fully the resources of the medical and scientifically related communities, including the competent scientists in industry, to develop criteria that in the long run will raise standards to further minimize the risks inherent in new drug development. It is not our purpose to interfere with the development of useful new drugs but to promote a responsible approach utilizing the best available methodology.

We have discussed some problems relating to investigational drugs. It is not possible in a limited time to discuss all of the aspects of the problem. I, for one, believe we cannot reasonably furnish a blueprint for a general plan of investigational studies of new drugs. I believe, however, that scientists, whether they are from industry or government, can easily agree as to the adequacy of any particular study and what constitutes a reasonable interpretation of its results. I am sure we will agree that the public health and a safe and effective drug supply are the first considerations.

WHAT PRICE HEALTH — HUMAN, THAT IS

In terms of dollars, when we contrast the scope of our current medical research effort to what we spend on other essential national activities, we are the gnat compared to the elephant. In the fiscal year of 1962, the Federal Government allocated $677 million through the National Institutes of Health to defend us against crippling and killing diseases, as compared with $2.8 billion for our farm price support and related programs. It allocated only $102 million to defend us against cancer, the cause of approximately one death every two minutes, compared with $158 million for agricultural research, including the health of cattle and pigs. It allocated $93 million for research against all heart diseases, America's number one killer, compared with $3.5 billion for the improvement of roads and highways. —David Sarnoff at Albert Lasker Medical Research Awards Luncheon, New York, Nov. 14, 1962.



Advances In Drug Research

PHYSICIANS CHOOSE PROSTAPHLIN, SANSERT AND SABIN ORAL POLIO VACCINE AS MOST SIGNIFICANT DRUGS OF 1962

Prostaphlin, Sansert, and the third Sabin oral polio vaccine were chosen in a poll of physicians as the most significant drugs introduced in 1962, it was reported in **FDC Reports,** a weekly drug-industry newsletter.

The poll is conducted annually to rate new drugs by **Medical Research Digest,** a Washington, D. C., publication which is mailed to 60,000 physicians in the United States. It asks doctors to vote (1) for the drugs they consider to be the most significant advance in medical therapy, (2) the drug most useful in their own practice, and (3) the drug most effective in easing the course of illness from the patient's point of view.

Prostaphlin is an oral synthetic penicillin that is effective against resistant staph infections. Sansert is indicated in the treatment of vascular headaches, and the new oral polio vaccine is effective against one form of polio.

Analysis of this year's physicians' replies shows:

(1) The new oral polio vaccine, (Sabin III), is the most significant advance in therapy, and Prostaphlin is second in this category;

(2) Prostaphlin is the new drug most useful in their own practice, and second place went to Persantin, a drug indicated in coronary deficiency, such as angina pectoris;

(3) Sansert was chosen as the 1962 drug most effective in easing the course of illness, with second place going to Prostaphlin.

Prostaphlin is a discovery of Bristol Laboratories of Syracuse, N. Y. Sansert was introduced by Sandoz Pharmaceuticals of Hanover, N. J., and the live-attenuated oral polio vaccine is the achievement of Dr. Albert B. Sabin, of the University of Cincinnati, as were types I and II which preceded it.

REVIVING THE PAST*

If bacteria could talk, those in a Philadelphia pharmaceutical laboratory would be a sell-out on a speaking tour. They were alive 700 years before Columbus discovered America, and not very long after the fall of the Roman Empire. They are alive today.

The bacteria have been restored to growth after lying dormant in a Mayan Indian tomb in Guatemala for 1,200 years. Studies are underway to determine whether they represent a form of biological life that no longer exists, or perhaps are the ancestors of some present organism that has undergone genetic changes. They might also offer space scientists clues for suspending life processes dur-



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Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

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ing years-long interplanetary journeys, and could lead to discovery of new and more effective drugs.

The venerable bacteria were collected by Dr. Joseph R. Valenta, a Smith Kline & French Laboratories microbiologist, from a tomb beneath the Temple of the Giant Jaguar in what was once the most powerful Mayan city-state. The tomb was opened several months ago by University of Pennsylvania archeologists, who removed the 500-pound stone covering its entrance, inserted a light, and recovered the opening with a plastic sheet to prevent contamination from outside.

Dr. Valenta donned sterile clothing and a gauze mask before descending into the chamber to collect samples. Using sterilized instruments, he spent 45 minutes gathering bits of dust and debris to carry back to his Philadelphia laboratory 2,000 miles away.

At S. K. & F., Dr. Valenta and fellow workers have revived the long-dormant bacteria in incubating devices which duplicate the temperature and humidity of the Guatemalan jungle. They also have obtained pure cultures by isolating the different types of organisms.

These isolates are of particular interest to geneticists, and could offer important information to other scientists, such as pathologists and biochemists. In addition, Dr. Valenta has grown and isolated a type of bacteria which he believes, based on experience, could lead to development of new antibiotics.

But scientists are not the only ones to benefit from study of the centuries-old bacteria. Investigation indicates the presence of certain disease-causing organisms which might have contributed to the decline of the Mayan civilization. While impossible to prove, this should give historians something to ponder — if not for another 1,200 years, at least for a long time to come.

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PHARMACY NEEDS DATA
MANPOWER SURVEY SHOWS

Reporting on a pilot survey of pharmacy manpower, Dr. Paul Q. Peterson, chief of the division of community health services, U. S. Public Health Service, told pharmacists at the 110th annual meeting of the American Pharmaceutical Association that "shortages in health manpower are among our most pressing health problems."

Peterson went on to say, "It is not enough to know the distribution of a profession and its academic training. We must have knowledge of its present role to be able to contemplate with any accuracy, its potential future contribution."

In the pilot survey done by Dr. Peterson and Maryland Y. Pennell, chief of PHS's health manpower branch, 91 percent of the pharmacists surveyed were employed in community pharmacies, eight percent were engaged in all other pharmaceutical activities such as manufacturing, wholesaling, research and teaching.

Dr. Peterson raised the question whether the profession was making an adequate contribution to research and teaching. He pointed out that "sufficient data were accumulated to cause the profession to concern itself with these problems."

Peterson bluntly told his audience of 3,000 registrants and guests of APhA that pharmacy must have data on its manpower comparable to that available for medicine and dentistry. He charged pharmacy to take its place along with its colleagues in the other health professions, or demonstrate indifference through inaction on a definitive manpower study.

APPLE PREDICTS SPREAD OF Rx
PREPAYMENT

"One of the most dramatic developments in the near future will be the spread of prescription prepayment." So stated William S. Apple, executive director of the American Pharmaceutical Association at the 110th annual meeting of the professional organization in Miami Beach, May 12-17.

He went on, "The public wants it and the



public will get it regardless of the obstacles placed in the way by the government or anyone else."

Dr. Apple commented on press reports which indicate the Justice Department's antitrust division "looks with a jaundiced eye on a prescription prepayment program developed by a carrier after prior consultation or discussion with people or groups in pharmacy." He further pointed out that even "the most innocent type of discussion on a vital public program can be somehow woven into the web of events when the finger is pointed at you."

Dr. Apple continued, "Physicians have been talking and acting in this area for the past two decades" and he noted recent reports in the press which said physicians were meeting to discuss the new fee schedule on the Blue Shield plan.

"I am aware," he added, "of the differences between the position accorded medicine and pharmacy by many people in the government and, unfortunately, too many people in the public generally . . . The physician who hires a technician to handle his x-rays and who limits himself to the professional service of reading them, apparently can meet with other physicians who do the same thing to discuss fees based on 100 percent of costs. . . . There must be something wrong with the way we practice pharmacy and the way we talk about our profession which makes it possible for judges to find that we are engaged only in a business of handling and selling commodities."

Challenging the pharmacists to face up to their professional standing, he concluded, "We are bombarded with advice that any change — except in the direction away from our profession — represents day-dreaming. Who can assure us that our goals are attainable or unattainable until many more among us have the courage of their professional convictions to give them a real chance. There are going to be changes in our area of the health field at a time when we are facing unparalleled problems. Is it possible that we are missing the boat by our desperate efforts to swim against the tide of change?"

PRESIDENT'S PAGE



I have just finished filling a prescription for one of the latest antibiotic drugs. It will cost several dollars. The customer will probably complain about the price—although they are somewhat conditioned as to cost by now. I know, however, that the customer is getting the largest bargain he can buy on today's market.

This takes me back to the early days of my pharmacy career. The medicines we had were mostly for treating symptoms. We prepared most of them in the pharmacy. This took a lot of time—but we had a lot of time. The average pharmacy work week was around 80 hours. Customers at that time complained about prices too. That part has not changed. For this work we received about $75.00 a month and were glad to get it. Those were the good old days. May I never see the likes of them again.

President
Wayne C. Shanholtz



APhA INSTALLS NEW OFFICERS

Robert J. Gillespie of St. Joseph, Michigan was installed as president of the American Pharmaceutical Association at ceremonies concluding the 110th annual meeting of the professional organization, May 17.

Taking office with him were **John Stadnik** of Miami Springs, Florida, first vice president; **Mike Harris** of Phoenix, Arizona, second vice president; and **Lee E. Eiler** of Dayton, Ohio, **William B. Hennessy** of Detroit, Michigan and **Linwood F. Tice** of Philadelphia, Pennsylvania, councilors.

Thomas A. Foster was chosen honorary president of the Association.

The nominating committee presented the following slate for 1964-65:

For President:
H. C. McAllister
J. Curtis Nottingham

For First Vice President:
Thomas J. Macek
Joseph V. Swintosky

For Second Vice President:
James W. Alexander
Emory J. Herndon

For Councilors:
Max W. Eggleston
Robert E. Lee
Fred T. Mahaffey
Lloyd M. Parks
Henry R. Peters
W. R. Whitten

At the close of House of Delegates session **Calvin Berger** was elected chairman of the House of Delegates and **Robert C. Johnson** was chosen vice chairman.

JOINT AMA, APhA, NARD COMMISSION TO STUDY INTERPROFESSIONAL RELATIONS

The American Pharmaceutical Association, the American Medical Association and the National Association of Retail Druggists have established a new joint Commission on Medicine and Pharmacy to closely examine the interprofessional relationship between the professions of medicine and pharmacy.

This joint Commission is co-sponsored by AMA, APhA and NARD, and will be composed of eight members, four from medicine and four from the profession of pharmacy.

Decision to establish this joint Commission climaxed a meeting Friday, May 24, at AMA headquarters in Chicago, when representatives of the American Pharmaceutical Association and the National Association of Retail Druggists met with the AMA Board of Trustees and Judicial Council on the problem of physician ownership of pharmacies. Following a two-hour conference with the APhA and NARD representatives, the AMA Board of Trustees voted to co-sponsor the new joint Commission.

Representing pharmacy at the Chicago meeting were APhA President **Robert Gillespie**, NARD President **Frank Lobraico**, APhA Executive Director **William S. Apple**, NARD Executive Secretary **Willard Simmons**, **Lee Eiler** and **Robert F.**

Abrams of APhA and **Frank Moudry, R. R. Rooke** and **Robert P. Fischelis** of NARD.

BLISS WILSON NAMED NABP PRESIDENT

Bliss C. Wilson, secretary of the South Dakota State Board of Pharmacy, was installed as president of the National Association of Boards of Pharmacy at the 59th annual meeting of the group. He succeeds **Peter J. Hauper** at the post.

NABP met in conjunction with the 110th annual meeting of the American Pharmaceutical Association which drew an attendance of more than 3,000 pharmacists and visitors at the Americana Hotel, Miami Beach, Florida.

Installed with Bliss Wilson at the concluding sessions were **Harold Whithead** of Virginia, honorary president; **Emory J. Herndon** of Utah, vice president; **Fred T. Mahaffey** as secretary, and **Alfred Duncan** of Arizona, treasurer.

The Executive Committee is composed of **Peter J. Hauper** of Wisconsin and **Felix Blanc** of Connecticut.

Francis S. Balassone of Maryland was elected to a five-year term on the Resolutions Committee.

GLENN L. JENKINS NAMED 1963 REMINGTON RECIPIENT

Dr. Glenn L. Jenkins, dean of the School of Pharmacy at Purdue University since 1941, and past president of the American Pharmaceutical Association, has been named the 1963 Remington Honor Medalist.

Dr. Jenkins is the 39th recipent of the award which was established in 1918 by the New York Chapter of the American Pharmaceutical Association, for the individual who has done most for American pharmacy. The Jury of Award, consisting of the past-presidents of the American Pharmaceutical Association, met during the Miami Beach annual meeting to make the 1963 selection.

Dr. Jenkins was cited by the Remington Honor Award Committee in recognition of his outstanding service to pharmaceutical education, to the American Pharmaceutical Association, and to the profession of pharmacy as a whole.

PHARMACY FRATERNITY INITIATES 16 AT STATE COLLEGE

Sixteen South Dakota State College students were recently initiated into Gamma Kappa chapter of Kappa Psi, largest pharmaceutical fraternity in the nation.

Initiates include the following: **Dwayne A. Plender,** Orange City, Iowa; **Ken L. Henjum,** Sioux Falls; **James R. Stephens,** Webster; **Robert J. Neumayr,** Parkston; **Dale K. Eads,** Beaver Creek, Minn.; **Steven L. Hoy,** Hot Springs; **Thomas D. Strand,** Ortonville, Minn.; **Ted A. Westley,** Aberdeen; **Allen W. Leske,** Madison, Minn.; **Arvid R. Liebe,** Milbank; **Roger A. Zobel,** Lake Park, Iowa; **J. Thomas Rahilly,** Watertown; **Don R. Spawn,** Brookings; **Nick J. Marchiando,** Spearfish; **Richard D. Haveman,** Miller; and **James L. Nelson,** Forest City, Iowa.

SOUTH DAKOTAN ELECTED INTO FELLOWSHIP IN ACA

Welles C. EerNisse, prominent Rapid City pharmacist, was among 26 pharmacists in the United States and Canada to be elected into Fellowship in the American College of Apothecaries at their Mid-Year meeting in Bal Harbour, Florida, May 12th to 17th, 1963.

EerNisse is associated with the Family Prescription Service, Inc., of Rapid City.

P. H. COSTELLO RECEIVES HONORARY DEGREE

Dr. P. H. Costello, former North Dakota pharmacist and secretary of the National Association of Boards of Pharmacy, was awarded an honorary doctor of science degree by North Dakota State University at the institution's 69th annual commencement exercises in Fargo, June 2.

He is one of four persons to be so honored for outstanding achievement in agriculture, chemistry, education and pharmacy.

Dr. Costello served 20 years as secretary of the NABP before his retirement July 1, 1962. Prior to that, he owned and operated a drug store in Cooperstown, North Dakota.

STATE BOARD CONDUCTS EXAMINATIONS

Twenty candidates for licensure as registered pharmacists were given written, practical and oral examinations at Brookings, June 4, 5, and 6, by the South Dakota State Board of Pharmacy.

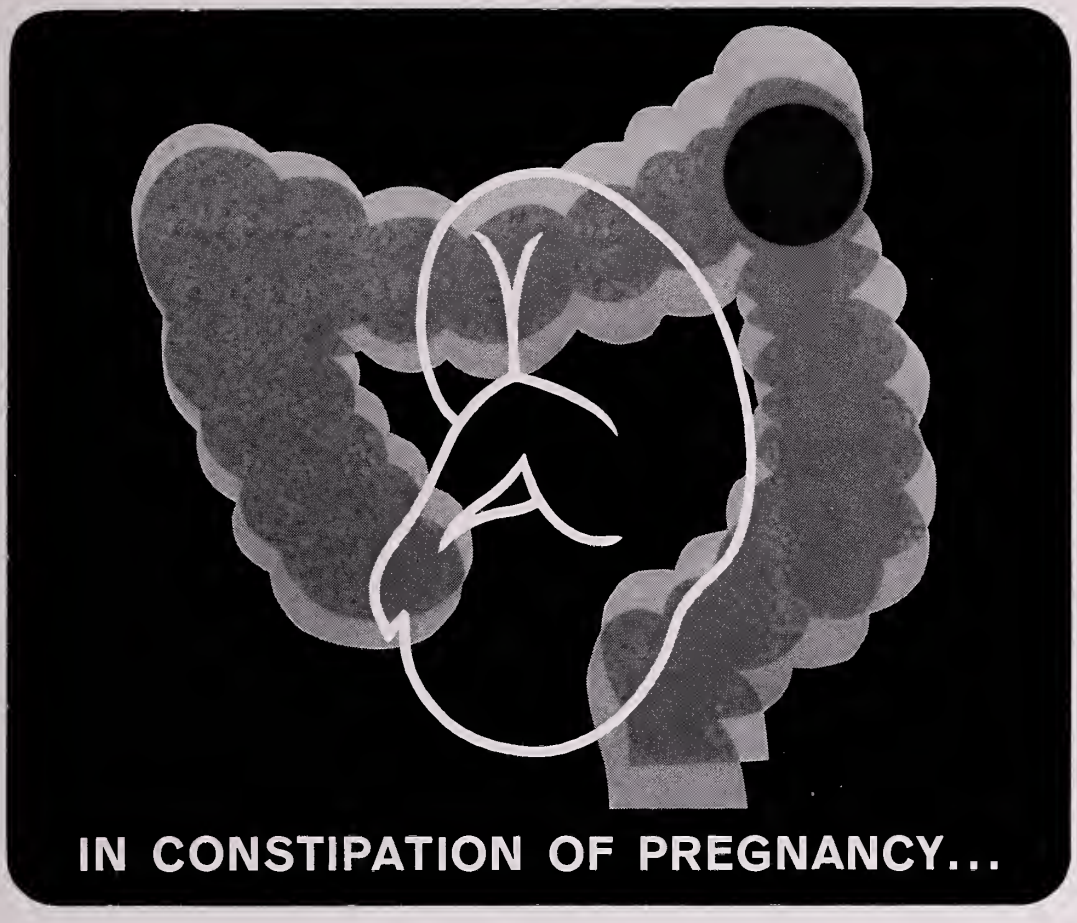
Conducting the examinations were Board members **Tom Haggar,** Watertown, **Roger Eastman,** Platte, and **Ted Hustead,** Wall. Assisting them were **Bliss Wilson,** Pierre, secretary for the Board, **Harold Schuler,** Pierre, publicity director, and **Harry Lee,** inspector.

There were no candidates for licensure by reciprocity.

FORTY-EIGHT PHARMACY STUDENTS GRANTED DEGREES AT STATE COLLEGE COMMENCEMENT

Forty-eight students of the Division of Pharmacy, South Dakota State College, were granted bachelor of science degrees at commencement exercises held June 3.

Those receiving degrees were **Don Aisenbrey,** Bonesteel; **Richard Alick,** Sioux Falls; **James Anderson,** Brookings; **Donna Arnsdorf,** Sturgis; **Norman Berg,** Marshall, Minn.; **Dewey Brown,** Arlington; **Richard Bucich,** Chicago, Ill.; **Kenneth Buck,** Waterville, Minn.; **Thomas Burton,** Hawarden, Iowa; **Charles Cofer,** Rapid City; **Connie Cottrell,** Aberdeen; **Delano Delzer,** Artas; **Dennis Dobesh,** Burke; **Gary Duerr,** Litchfield, Minn.; **Harvey Eernisse,** Leota, Minn.; **Clarence Else,** Marshall, Minn.; **Wallace Fairfield,** Wessington Springs; **Marvin Feidler,** Scottsbluff, Nebr.; **Thomas Golden,** Austin, Minn.; **Robert Green,** Sisseton; **William Hankes,** Aurora, Ill.; **Albert Harper,** Wood; **Larry Harrington,** Sioux Falls; **Alan Henricks,** Austin, Minn.; **Duane Kallsen,** Struble, Iowa; **Louise Kemen,** Madison, Minn.; **Gale Kulm,** Mobridge; **Bruce Laughrey,** Brookings; **Robert Lester,** Brookings; **John Linden,** White Bear Lake, Minn.; **Cornelius Maris,** Sanborn, Iowa; **Richard Meidl,** New Ulm, Minn.; **Frederick Moskol,** Milwaukee, Wisconsin; **Rolland Nelson,** Brookings; **Karl Person,** Wakoe, Nebr.; **David Powell,** Brookings; **William Reimer,** Leola; **Sally Schlepp,** Aberdeen; **Lola Schuman,** Stratford; **Jerome Schweitzer,** Adrian, Minn.; **Don Squires,** Brookings; **Marcia Teig,** Highmore; **Charles Thornton,** Wessington Springs; **Frank Underhill,** San Diego, Calif.; **Warren Verdeck,** Marshall, Minn.; **Marlene Wallace,** Britton; **Darwin Ward,** Brookings; and **Larry Wiley,** Des Moines, Iowa.



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By adding a soft, hydrophilic, easily-compressed bulk to the diet, Metamucil augments and reinforces the natural bulk stimulus to intestinal peristalsis and the defecation reflex. This purely local action softens hard fecal masses, increases muscle tone and helps reestablish the normal rhythm of elimination.

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Average Adult Dose: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid.

Metamucil is available as Metamucil powder in 4-, 8- and 16-ounce containers and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

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In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

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carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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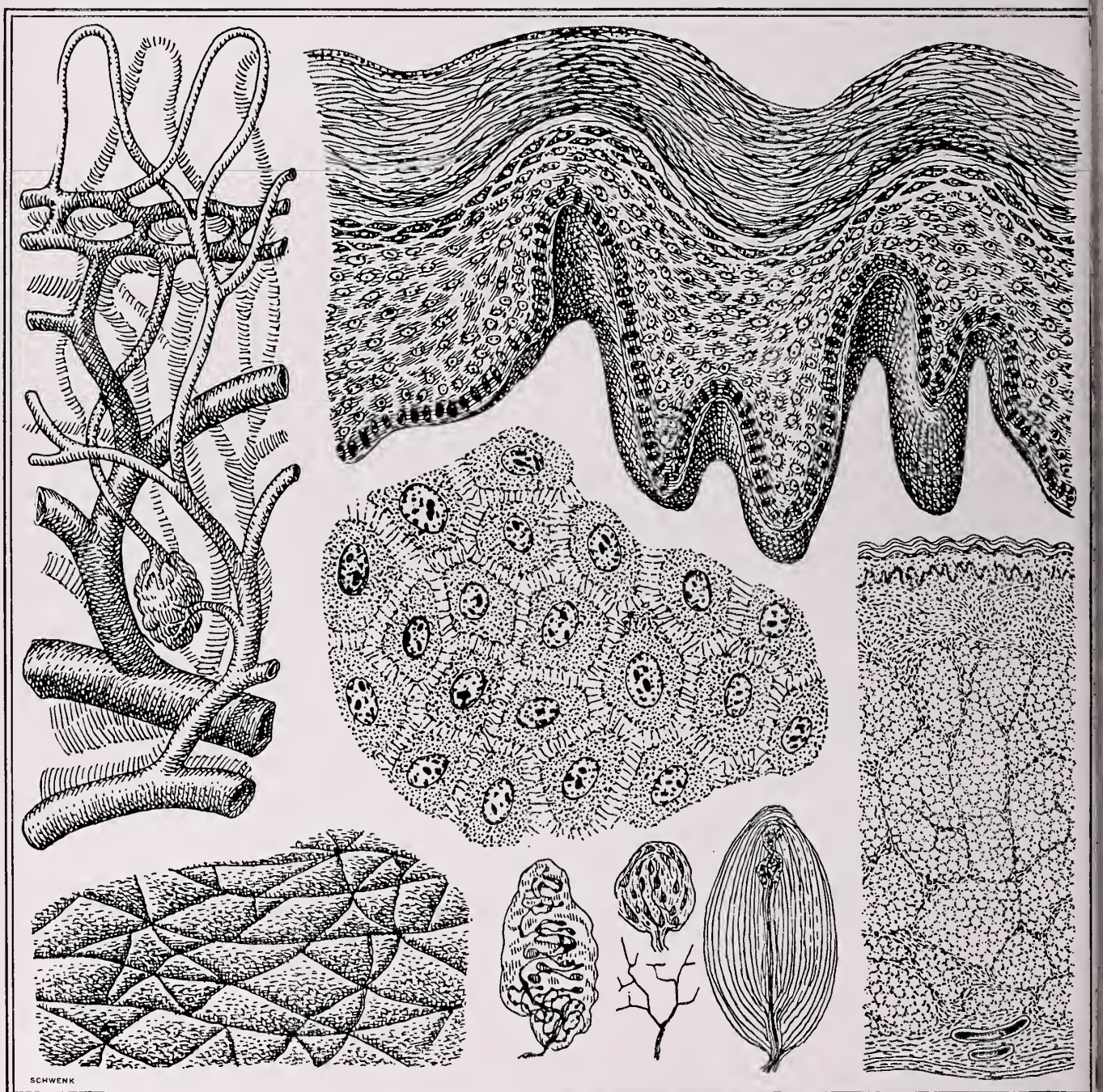
Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide...100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline...4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

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Skin Deep

Allergic and inflammatory dermatoses, including psoriasis, have in many patients shown dramatic response to ARISTOCORT Triamcinolone systemic therapy. But it also provides gratifying symptomatic control with only minimal interference with other metabolic functions. In this respect, ARISTOCORT Triamcinolone, when compared with other corticosteroids, old and new, is distinguished. Typical steroid problems of sodium retention and edema, undesirable euphoria, or voracious appetite and excessive weight gain rarely occur.

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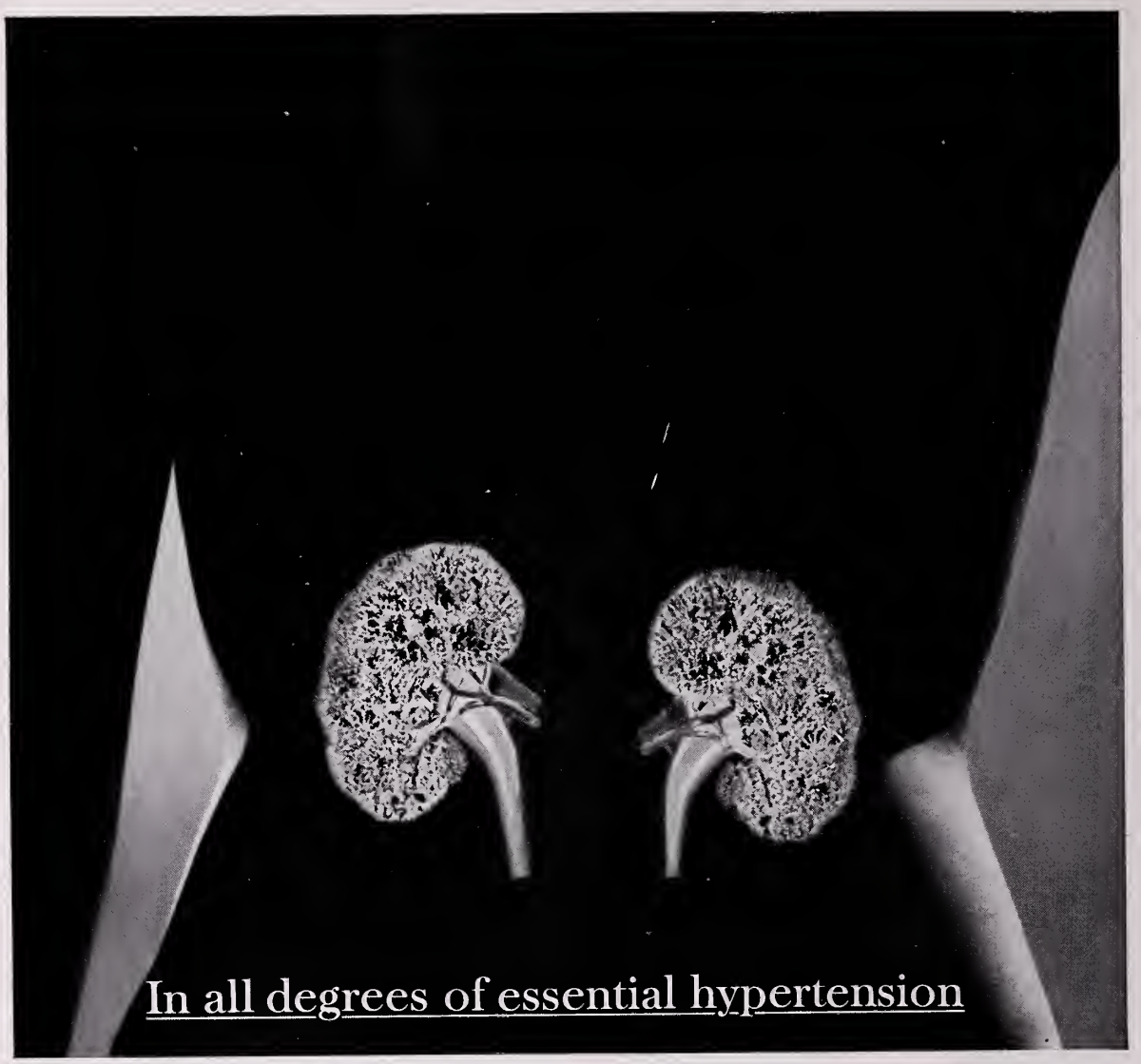
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FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup — 2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

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Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced.[1-2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality."[1] *Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients.* Rautrax-N is effective in mild,[3] moderate,[3,4] or severe hypertension.[4,5]

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

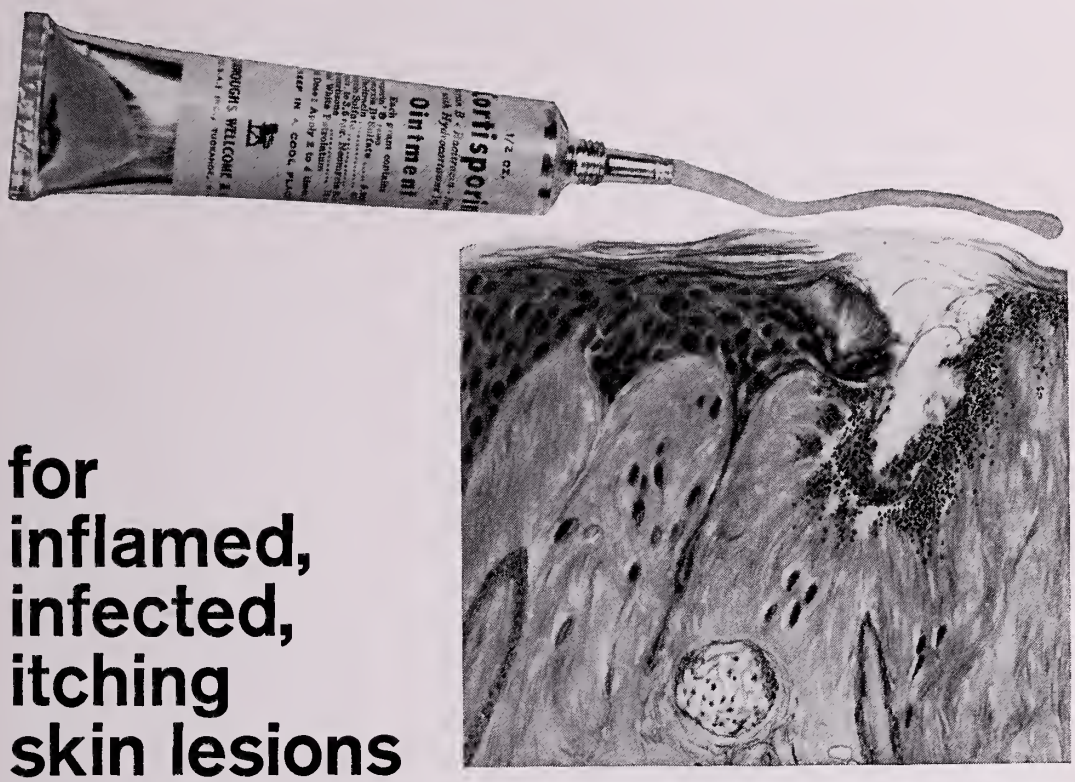
Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycosuria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. *Rautrax-N Modified*—50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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for inflamed, infected, itching skin lesions

anti-inflammatory / bactericidal / antipruritic

'CORTISPORIN'® brand OINTMENT

POLYMYXIN B-BACITRACIN-NEOMYCIN WITH HYDROCORTISONE 1%

Each gram contains:
'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg.; Hydrocortisone 10 mg. (1%).

- relieves pain and itching
- reduces inflammation and edema
- provides bactericidal action against most gram-positive and gram-negative organisms, including *Pseudomonas aeruginosa*
- rarely sensitizes

General Indications: Wherever inflammation or infection occurs and is accessible for topical therapy, as in burns, wounds, skin grafts; and plastic proctologic, gynecologic, or general surgical procedures.

Dermatologic Indications: Atopic, contact, stasis, infectious eczematoid, and lichenoid dermatitis; neurodermatitis, eczema, pyoderma; anogenital pruritus; primary dermatoses with or without secondary infection; external otitis.

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Contraindications: Local application is contraindicated in tuberculous conditions of the skin, herpes simplex, vaccinia and varicella.

Available: In tubes of ½ oz. with applicator tip and ⅛ oz. with ophthalmic tip. Although the ⅛ oz. tube is intended for ophthalmic use, it may be used topically.

Complete literature available on request from Professional Services Dept. PML.

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CHLORMEZANONE with ASPIRIN

*TRADEMARK 100 MG. 300 MG.

-1778M



The new or early hypertensive patient



The middle-aged hypertensive woman



The geriatric hypertensive patient



The overweight hypertensive patient



When depression or peptic ulcer adds problems



Effective blood pressure regulation for the many faces of hypertension[1-5]

Important note: For best results with CAPLA (mebutamate)

To demonstrate its blood-pressure-lowering effect, 'Capla' (mebutamate) must have been taken on schedule on the day of the patient's checkup. The maximum hypotensive response occurs within 2-4 hours. Because 'Capla' (mebutamate) is promptly excreted, q.i.d. dosage should be maintained for consistent results.

Product Information: 'Capla' (mebutamate) is indicated for control of hypertension, either alone in mild cases, or in conjunction with diuretics or peripherally acting hypotensive agents in more severe cases. Its mild tranquilizing properties are often found an additional benefit to its antihypertensive action.

Drowsiness and occasional lightheadedness, usually transient, are often signs of dosage higher than necessary for therapeutic effect. There are no known contraindications to mebutamate.

Usual Dosage: One 300 mg. tablet 3 or 4 times daily, before meals and at bedtime. Dosage should be adjusted to individual requirements; for example, older patients may require lower dosage.

Composition: Each tablet contains mebutamate, 300 mg.

Supplied: Bottles of 100 white, scored tablets. Literature and samples to physicians on request.

References: 1. Corcoran, A. C., and Loyke, H. F.: J.A.M.A. *181*:1043, Sept. 22, 1962. 2. Costello, A. C.: M. Times *91*:53, Jan. 1963. 3. Holloman, J. L. S., Jr.: J. Nat. M. A. *54*:94, Jan. 1962. 4. Kheim, T., and Kountz, W. B.: New York J. Med. *62*:1596, May 15, 1962. 5. Leslie, C. H.: J. Am. Geriatrics Soc. *10*:85, Jan. 1962.

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Get your low-back patient back to work in days instead of weeks

You can expect rapid results from 'Soma' (carisoprodol)—because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 41 days without it. (J.A.M.A., April, 1960.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

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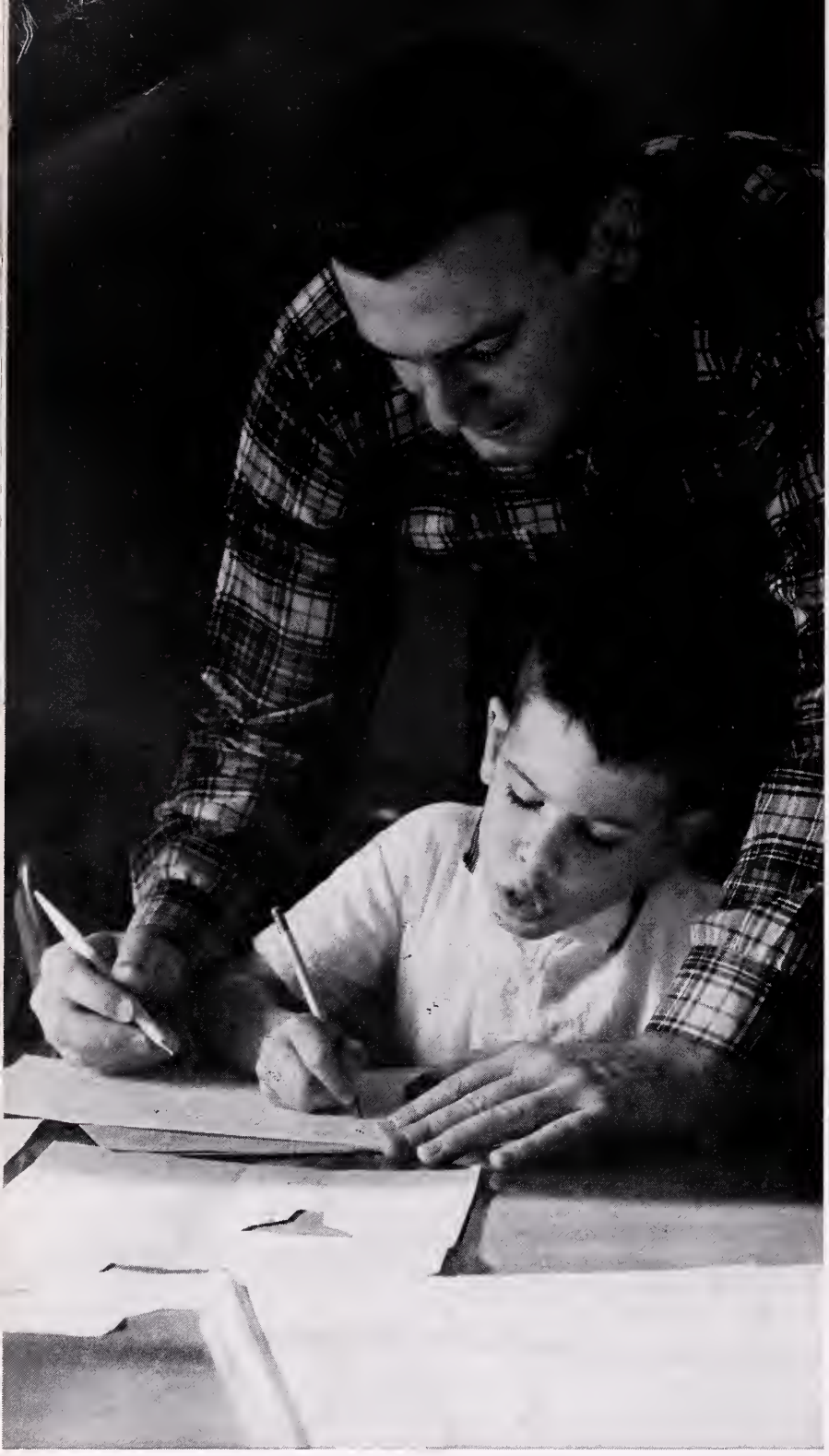
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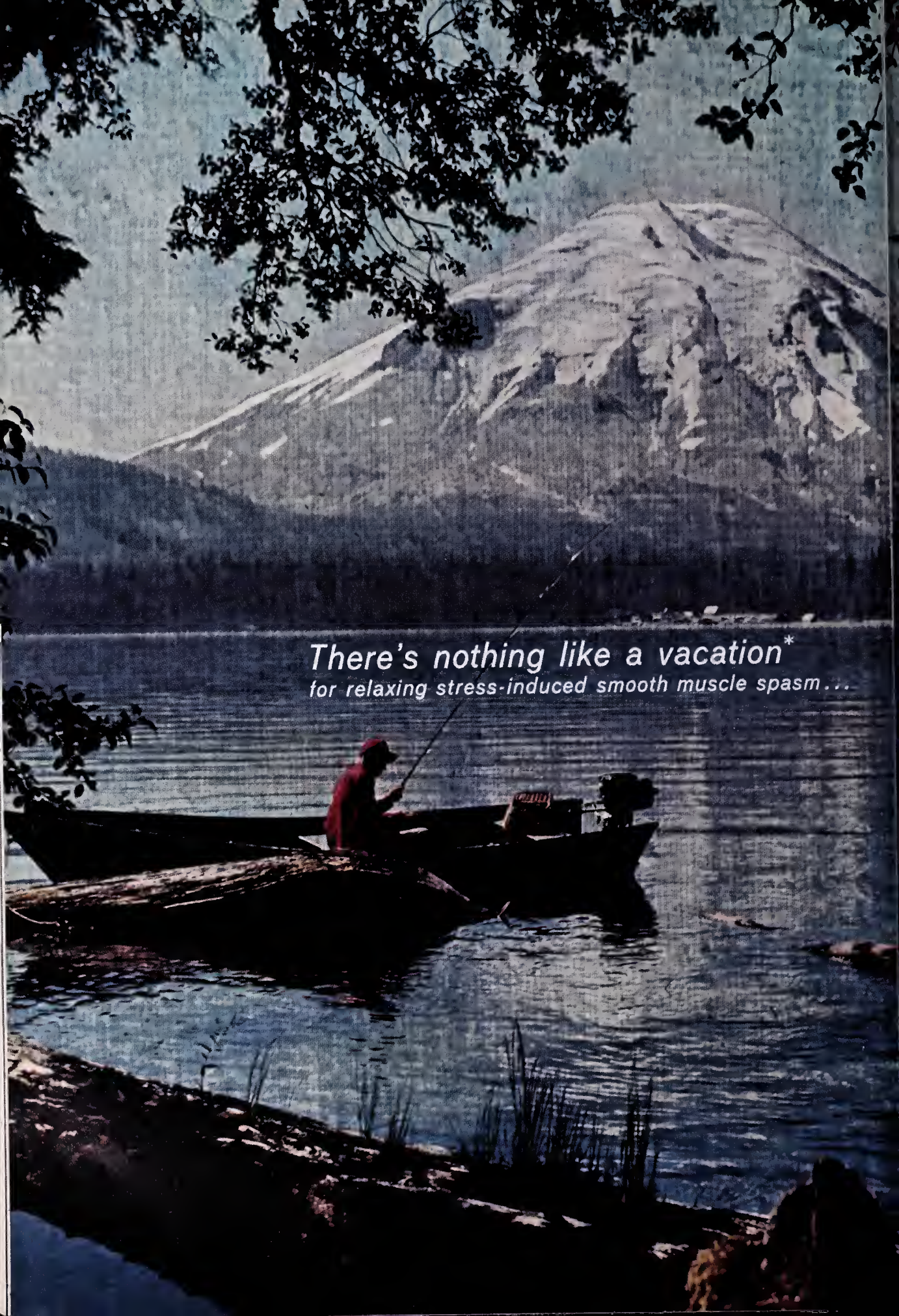
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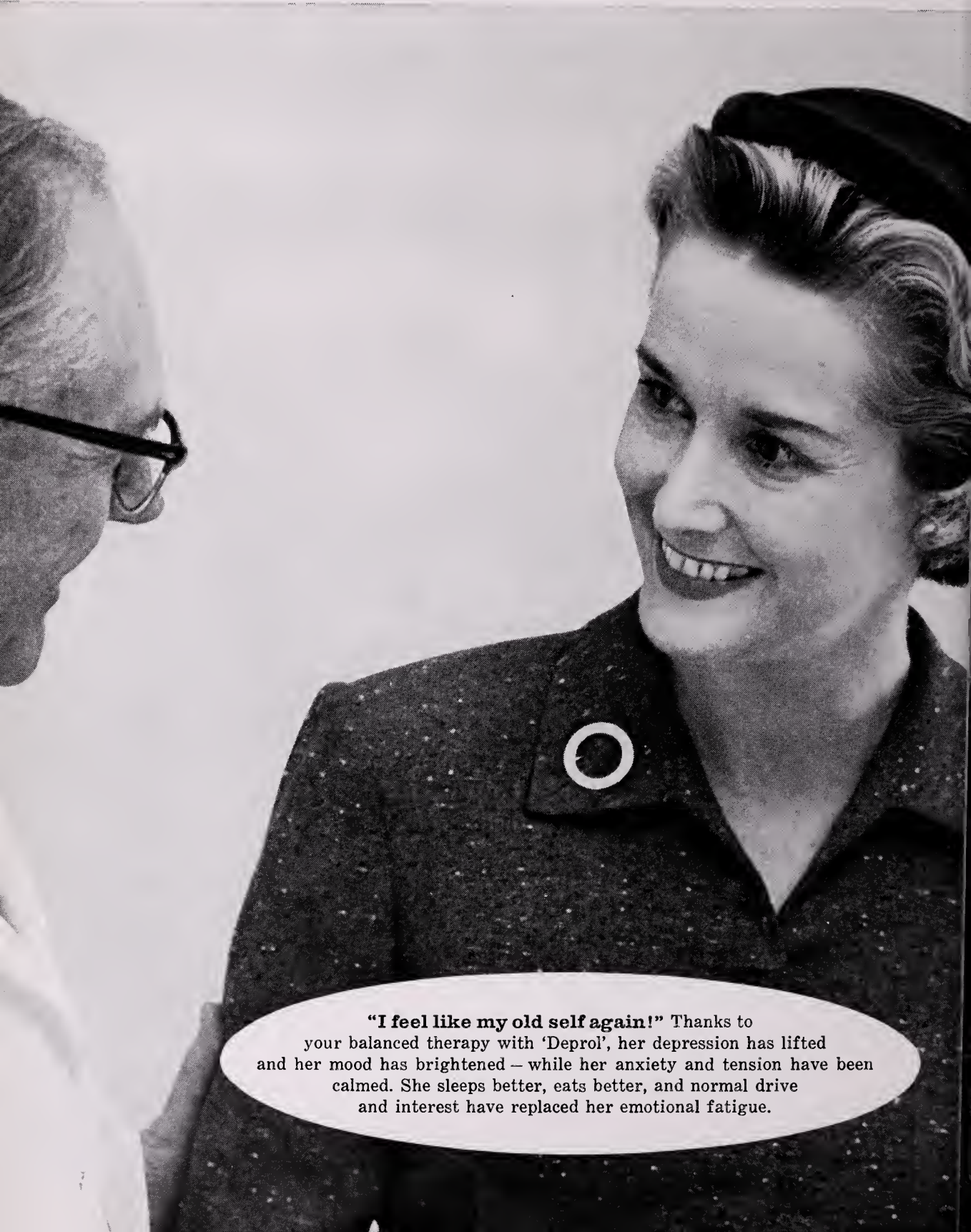
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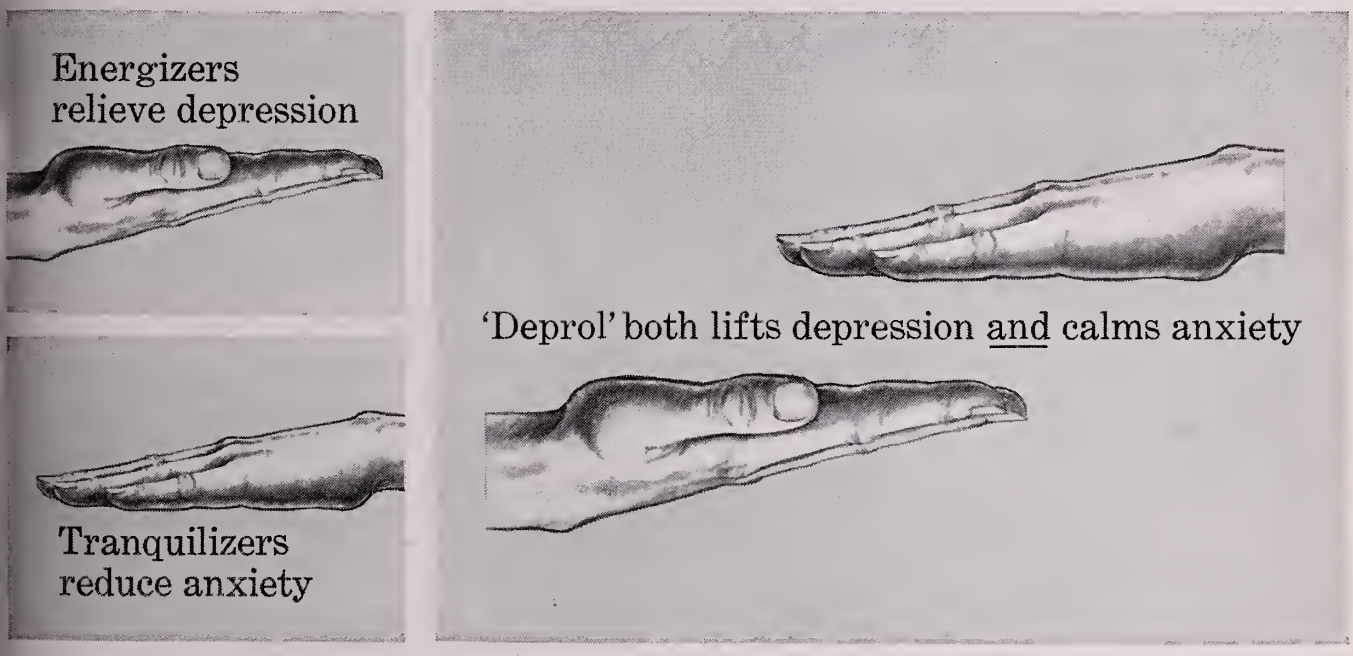
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1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

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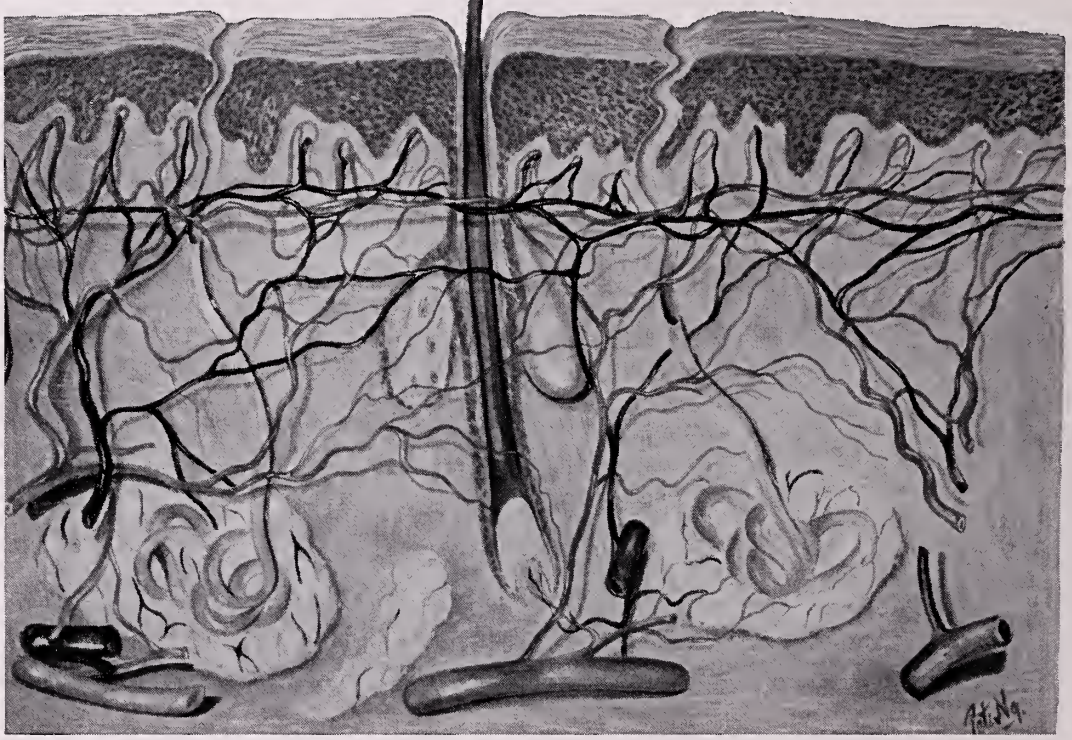
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1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

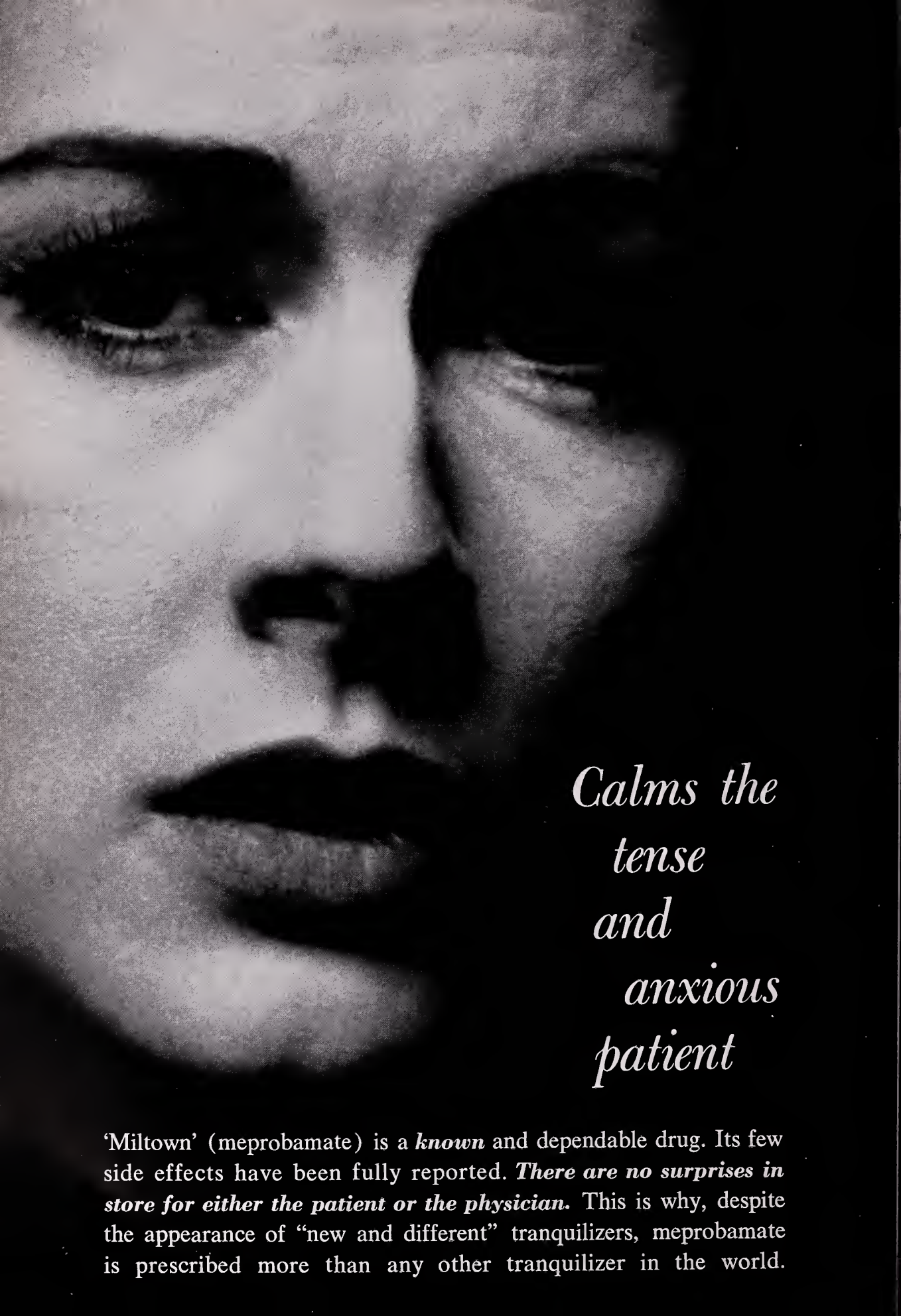
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Transactions of the South Dakota State Medical Association Eighty-second Annual Session June 8, 9, 10, 11, 1963

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Ted Hohm, M.D. ..... Huron
D. L. Ensberg, M.D. ..... Sioux Falls

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Dagfinn Lie, M.D. ..... Webster

AUDIT AND APPROPRIATIONS COMMITTEE MEETING

Saturday, June 8, 1963

Kochi Motel
Yankton, S. D.

The meeting was called to order at 1:20 P.M. in Room 44 of the Kochi Motel. Present were Drs. A. P. Reding, A. K. Myrabo, and R. F. Hubner.

The Committee discussed the audit prepared by the Certified Public Accountant of the Association accounts. Dr. Hubner moved that the Committee approve the audit as prepared. The motion was seconded by Dr. Myrabo and carried.

The Committee then discussed the budget which was submitted in January. Several minor changes were suggested, as follows:

1. Increase item of Salaries, Other, to $7,300.00
2. Increase the item of Legal and Audit from $600.00 to $700.00
3. Decrease the item of Office Supplies and Equipment from $3,000.00 to $2,725.00

Journal Budget

1. Eliminate the item of Salary, Staff
2. Eliminate the item of Social Security Tax
3. Increase item of Staff travel to $350.00
4. Increase item of Balance to Surplus to $13.00

Building Fund Budget

1. Increase item of Legal and Audit from $500.00 to $1,500.00
2. Reduce repayment of loans to $2,450.00

Dr. Myrabo moved that these changes be recommended to the Council for approval. The motion was seconded by Dr. Hubner and carried.

Dr. Hubner moved that Mr. Foster's salary be increased $150.00 per year to cover country club membership, from the Public Relations item. The motion was seconded by Dr. Myrabo and carried and will be recommended to the Council. The meeting adjourned at 2:30 P.M.

1963-1964 BUDGET

ESTIMATED INCOME — GENERAL FUND

State Dues	$40,000.00
Annual Meeting	6,300.00
Interest	200.00
Miscellaneous	1,045.00
Salary Reimbursement	100.00
Car Reimbursement	690.00
	$48,835.00

ESTIMATED EXPENSES — GENERAL FUND

Salary, Executive Secretary	$ 7,500.00
Salary, Other	7,300.00
Social Security	420.00
Legal & Audit	700.00
Telephone & Telegraph	1,500.00
Office Supplies & Equipment	2,725.00
Dues & Subscriptions	1,200.00
Officers Travel	2,200.00
Annual Meeting	5,000.00
Public Relations	4,000.00
Rent	2,400.00
Unemployment Taxes	40.00
Postage	1,600.00
Legislative Expense	1,850.00
Benevolent Fund	400.00
Medical School Endowment	200.00
Ladies Auxiliary	1,000.00
Refunds	200.00
Car Expenses	860.00
Staff Travel	4,500.00
Clinical Pathology	1,000.00
Miscellaneous	500.00
Reserve	1,000.00
Balance to Surplus	740.00
	$48,835.00

JOURNAL—INCOME

Advertising	$24,000.00
Subscriptions	1,200.00
Miscellaneous	750.00
Refunds	100.00
	$26,050.00

JOURNAL—EXPENSES

Salary, Business Manager	$ 3,600.00
Salary, Editors	1,440.00
Legal & Audit	50.00
Rent	900.00
Telephone & Telegraph	175.00
Office Supplies	17,842.00
Taxes	30.00
Unemployment Taxes	
Postage	250.00
Travel Expense	350.00
Balance to Surplus	13.00
Due Midwest-Beach from '62-63	1,400.00
	$26,050.00

GROUP LIFE INSURANCE INCOME

Premiums	$30,000.00

EXPENSES

Payments to Insurance Company	$29,100.00
Postage	50.00
Legal & Audit	50.00
Supplies	50.00
Balance to Surplus	750.00
	$30,000.00

BUILDING FUND INCOME

Blue Shield Rent	$ 4,800.00
Association Rent	2,400.00
Journal Rent	900.00
Board of Examiners Rent	300.00
Nurses Association Rent	900.00
OAA Rent	2,250.00
	$11,550.00

EXPENSES

Janitor & Repair	$ 1,400.00
Utilities	1,600.00
Interest	2,600.00
Repayment of Loans	2,450.00
Taxes & Insurance	2,000.00
Legal & Audit	1,500.00
	$11,550.00

FIRST COUNCIL MEETING
June 8, 1963
Kochi Motel
Yankton, South Dakota

The first Council meeting of the 82nd annual meeting was called to order by the Chairman, E. P. Sweet, M.D., at 3:15 P.M.

The following members were present for roll call: Drs. Magni Davidson, R. H. Hayes, J. Patrick Steele, A. P. Reding, C. J. McDonald, E. J. Perry, J. J. Stransky, M. C. Tank, L. C. Askwig, Paul Hohm, Preston Brogdon, E. T. Lietzke, T. H. Sattler, J. T. Elston, E. P. Sweet, H. E. Lowe, and E. A. Johnson.

Dr. McDonald moved that the reading of the minutes of the last meeting be dispensed with inasmuch as they have been published in the South Dakota Journal of Medicine. The motion was seconded by Dr. Perry and carried.

Mr. Foster discussed the actions that have been taken and those contemplated on the exemption of the Medical Association building for tax purposes.

The report of the Medical Legal Committee was read.

REPORT OF THE MEDICAL LEGAL COMMITTEE

The Medical Legal Committee has been asked to submit a report on its study to implement the creation of a working Medical-Legal Panel.

At a meeting held on February 26, the Committee talked with representatives of the Bar Association and determined to check carefully into the operation of other such panels. The Executive Secretary was instructed to obtain information which is now in the hands of the Committee, but has not been completely analyzed and no recommendations have as yet been made.

We request that the Council allow the Committee to spend such additional time as may be needed in completing recommendations.

Respectfully submitted,
MEDICAL LEGAL COMMITTEE
C. L. Swanson, M.D.
D. L. Ensberg, M.D.
Ted Hohm, M.D.

Dr. Steele moved that the Council accept the report, asking that a final report be submitted to the Council at the January, 1964, meeting. The motion was seconded by Dr. Hayes and carried.

Dr. Steele moved that the matter of implementing the Self-Employed Individual Tax Retirement Act be tabled until the September Council meeting. The motion was seconded by Dr. Davidson and carried.

Dr. Reding read the Report of the Budget and Audit Committee. Dr. Reding moved that the Council accept the report. The motion was seconded by Dr. Tank and carried.

The CPA Audit of the Association accounts was presented for the information of the Council.

SOUTH DAKOTA STATE MEDICAL ASSOCIATION CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED APRIL 30, 1963

Receipts:	
State Dues	$43,400.00
Annual Meeting	5,877.96
Miscellaneous Income	1,530.37
Amer. Med. Asso. dues	17,895.00
Medicolegal Conference	2,393.05
Interest Earned	299.72
Ins. Premiums Collected	35,692.50
Salary Reimbursement	574.91
Blue Shield — car expense reimbursement	690.00
Refunds	3,761.78
Advertising	27,147.45
Subscriptions	755.00
Reprints	607.62

Transfer from General Account	1,000.00	
Rent	10,099.25	
Group Insurance—Dividend	2,775.34	
Total receipts		$154,509.95
Expenses:		
Salary—executive	$11,100.00	
Salary and commissions — others	14,038.58	
Social security tax expense	529.80	
Legal and audit	801.00	
Rent and insurance	2,503.73	
Telephone and telegraph	1,693.39	
Office and operating supplies	22,710.50	
Dues and subscriptions	1,095.19	
Travel expense	6,994.15	
Annual meeting	514.95	
Interest expense	3,163.48	
Public relations	4,507.24	
American Medical Association dues	17,570.00	
Taxes, licenses, postage and miscellaneous	2,529.08	
Legislative expense	2,523.32	
Donations and transfer of funds	2,740.01	
Ladies Auxiliary expense	665.45	
Insurance premiums remitted	32,654.42	
Refunds	305.37	
Medicolegal expense	2,024.65	
Depreciation expense	5,797.77	
Utilities, repairs and maintenance	1,994.64	
Total expenses		$138,456.72
Net Profit to Net Worth		$ 16,053.23

Letters were read concerning the proposed change in the law regarding physicians confidential relations privilege from Mr. Ross Oviatt of Watertown and Karl Goldsmith, attorney for the Association. Dr. Stransky moved that this matter be referred to the Committee on Legislation and request that the Committee contact the American Medical Association and the California Medical Association for additional opinions on this subject; that the Committee report back to the Council at the September meeting. The motion was seconded by Dr. Sattler and carried.

The Vaccination Assistance Act was discussed. A statement submitted by Dr. Van Heuvelen on this program was read as follows:

Congress has recently enacted legislation making available Vaccination Assistance Projects Grants to assist states in carrying out intensive vaccination programs to protect their population, especially all children under age 5, against poliomyelitis, diphtheria, pertussis and tetanus. In order for a state to avail itself of these funds it must provide for a program which would include all of the four diseases mentioned and be designed to achieve the vaccination of all or practically all susceptible persons in a community. The term "susceptible persons" is interpreted to include at least those unvaccinated or inadequately vaccinated persons under the age of 30 (or, in the case of pertussis, under the age of 5). The funds when available can be used for the purchase of vaccines for use in immunizing children under age 5. They cannot be used for purchase of vaccines for persons of 5 years or over, for the payment of physicians or nurses services in their administration, or for equipment, supplies or facilities that may be used.

The State Department of Health has no interest in setting up large numbers of free vaccination clinics nor does it want to interfere in any respect with normal physician-patient relationships, especially with regard to immunization of infants and other pre-school children. It is therefore proposed that a program be established which would provide for distribution of free vaccine upon request to practicing physicians. The physicians would be asked to certify that all such vaccine was used solely for immunization of children under 5 years of age and that no charge was made for the vaccine. (The physicians would be permitted to make a charge for professional services exclusive of vaccine costs.) Reports on individual doses given would not be required since federal auditors have agreed that the above mentioned certificates would satisfy accountability requirements. The certificate would indicate any loss of vaccine that may have occurred through spoilage, waste, breakage, etc.

It is anticipated that vaccine assistance grants will be available only until July 1, 1965, and that in the meantime a concerted effort will be made to have all susceptible persons immunized.

Dr. Steele moved that the Council recommend that the State decline to accept funds from the Federal Government for this program and that the physicians in the State continue to carry out their own local vaccination programs in South Dakota. The motion was seconded by Dr. Elston and carried.

Mr. Foster spoke to the Council on the Conference on Aging which he attended in Washington, D. C. He discussed a proposed Conference on Aging to be held in South Dakota this fall, in cooperation with other interested organizations. Dr. Steele moved that such a meeting be set up and sponsored by the South Dakota State Medical Association in cooperation with other agencies interested in the problem. The motion was seconded by Dr. Sattler and carried.

A letter was read requesting a representative from the Medical Association be present at a National Conference on Institutionally Acquired Infections to be held this fall. Dr. Steele moved that Dr. John Elston attend the meeting as a representative of the State Association and that a paper be prepared following the meeting for inclusion in the South Dakota Journal of Medicine for the information of the members. The motion was seconded by Dr. Perry and carried.

Dr. Perry moved that Dr. W. A. Geib be named as an alternate representative, if Dr. Elston is unable to attend. The motion was seconded by Dr. Tank and carried. It was suggested that the report, when available, be furnished to every hospital administrator in the State, with the request that the report be discussed at a hospital staff meeting.

A request for funds from the National Society for Medical Research was read. Dr. Steele moved that the Association donate $75.00 to this Society. The motion was seconded by Dr. Hayes and carried.

A request from the National Society for Medical Research asking for assistance and help in their program was considered. Dr. Brogdon moved that the request be tabled until the September Council meeting and additional information is obtained from the Society. The motion was seconded by Dr. Reding and carried.

Mr. Foster read a letter from Olga Ulberg, executive secretary of the South Dakota Nursing Home Association regarding a meeting on accreditation of nursing homes. Dr. Steele moved that the Association send Richard Erickson to the meeting as an observer and that he report back to the Council at the September meeting on their plans. The motion was seconded by Dr. Davidson and carried.

Mr. Foster explained the method of appointment

to the Interprofessional Health Council and the proposed change. Dr. Steele moved that the appointments be filled by position, rather than by individuals as is done at the present time; that the representatives of the medical profession on this Council be the Secretary of the Medical Association, the Secretary of the South Dakota State Board of Medical and Osteopathic Examiners, and the Executive Secretary of the Medical Association. The motion was seconded by Dr. Askwig and carried.

Dr. Perry moved that the meeting be adjourned at 4:30 P.M. The motion was seconded by Dr. McDonald and carried.

SECOND COUNCIL MEETING

June 10, 1963
Black Steer Restaurant
Yankton, South Dakota

The second Council meeting was called to order by Dr. E. P. Sweet, Chairman, at 10:15 P.M. The following members were present for roll call: Drs. Magni Davidson, R. H. Hayes, J. Patrick Steele, A. P. Reding, E. J. Perry, J. J. Stransky, M. C. Tank, Preston Brogdon, E. T. Lietzke, T. H. Sattler, E. P. Sweet, E. A. Johnson, and Robert Giebink.

Dr. Hayes moved that the reading of the minutes of the previous meeting be dispensed with inasmuch as they will be published in the Journal. The motion was seconded by Dr. Tank and carried.

Dr. Tank nominated Dr. E. J. Perry for Chairman of the Council. Dr. Davidson moved that nominations cease and that a unanimous ballot be cast for Dr. Perry. The motion was seconded by Dr. Brogdon and carried. Dr. Perry then took over the Chair and conducted the rest of the meeting.

Dr. Perry introduced the new members of the Council. Fred Leigh, M.D. is the Councilor from the Huron District Medical Society, but was not present at the meeting. Dr. Robert Giebink is the new Speaker of the House and was introduced to the Council.

Mr. Richard Erickson briefly discussed the implementation of "Operation Hometown" which will be carried out this summer by the executive office. The president was directed to implement the program.

The recommendation to revise the committee structure of the Association was discussed. Dr. Stransky moved that the Chairman of the Council appoint a committee to work with the executive secretary on the revisions and report to the Council at the September meeting with concrete proposals, and that the Council receive the information for study prior to the Council meeting. The motion was seconded by Dr. Brogdon and carried.

Dr. Perry appointed Drs. Sattler, Brogdon, Leigh, and Lietzke to serve on this committee.

Dr. Brogdon discussed the fee schedule negotiated with the Welfare Department for the Ophthalmologists under the OAA program. Dr. Brogdon moved that the problem be referred to the Executive Committee for study. The motion was seconded by Dr. Steele and carried.

Dr. Stransky discussed the loss-of-time insurance programs now endorsed by the State Association. He moved that the State Association office inform the Harold Diers Company and the Combined Insurance Company of America not to send out any further promotional literature, using the Association's name, until the Medical Economics Committee is willing and able to function, and to refer these insurance programs to the Medical Economics Committee for a study in depth on the long range and short range effect on the Society of these programs; that the Medical Economics Committee report back to the Council at the January meeting on their findings. The motion was seconded by Dr. Davidson and carried.

Mr. Erickson discussed the recommendation to the Council from the Blue Shield Board of Directors on re-activating the Fee Advisory Committee to review the Relative Value Scale. The Fee Advisory Committee consists of representatives from each specialty group and each District Medical Society. Dr. Stransky moved that the Fee Advisory Committee be re-activated to carry out this review. The motion was seconded by Dr. Tank and carried.

The meeting was adjourned at 11:00 P.M.

FIRST HOUSE OF DELEGATES MEETING

The meeting was called to order at 7:45 P.M. by Dr. C. J. McDonald, Speaker of the House. The following delegates were present for roll call: Drs. C. L. Vogele, R. E. Bormes, G. F. McIntosh, W. T. Sweeney, G. Robert Bartron, T. J. Wrage, Jr., Donald Scheller, J. A. Anderson, R. C. Jahraus, H. Werthmann, C. S. Swanson, F. D. Leigh, Yale Charbonneau, E. H. Mueller, C. F. Binder, R. Giebink, J. Donahoe, G. M. Jameson, A. K. Myrabo, E. W. Sanderson, C. A. Stern, S. M. Brzica, T. A. Angelos, Bill Church, R. J. Foley, T. H. Willcockson, R. Bareis, T. Jacobson, F. Gilbert, C. J. Blunck, M. R. Cosand, C. A. Johnson, V. Janavs, Magni Davidson, R. H. Hayes, A. P. Reding, C. J. McDonald, R. H. Quinn, E. J. Perry, J. J. Stransky, M. C. Tank, L. C. Askwig, Paul Hohm, Preston Brogdon, E. T. Lietzke, T. H. Sattler, J. T. Elston, E. P. Sweet, and E. A. Johnson.

Dr. Perry moved to dispense with the reading of the minutes of the last meeting inasmuch as they have been published in the Journal. The motion was seconded by Dr. Elston and carried.

Dr. McDonald explained that this meeting was also a general membership meeting for the purpose of amending the Bylaws and Articles of Incorporation. Notices were mailed to the membership of the Association thirty days prior to the meeting. The proposed changes were read as follows.

PROPOSED AMENDMENT TO ARTICLES OF INCORPORATION OF THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

ARTICLE XI

This Corporation shall not be subject to any grand, supreme, or sovereign lodge or any superior body or bodies.

ARTICLE XII

The amount of property which this Corporation may hold shall be unlimited, and shall be in such quantity and amount as authorized and approved by the House of Delegates at any annual meeting or special meeting called for the purpose of determining property to be held by the Corporation.

ARTICLE XIII

In the event this Corporation shall be dissolved, voluntarily or involuntarily, all of the corporate assets of this Corporation, wherever situated and of whatsoever character, remaining after the payment of all of its obligations, in the manner provided by law, shall be paid or conveyed to the School of Medicine of the University of South Dakota and in the event such School of Medicine is unable or unwilling to accept, said assets shall be distributed to the State of South Dakota to be used for the betterment of public health.

ARTICLE XIV

The private property of the members of this corporation shall not be liable for corporate debts.

ARTICLE XV

These Articles of Incorporation may be amended at any Annual Meeting of the membership by a vote of a two-thirds majority of members then and there present, and such meeting shall authorize and empower the President, Vice President and Secretary of the Association then in office to pre-

pare Amended Articles of Incorporation and make application to the Secretary of State for a Certificate of Amendment as provided by the laws of the State of South Dakota in the case of other corporations. The Amendment to the Articles of Incorporation shall be acknowledged by the President, Vice President and Secretary of the Association who shall append thereto an affidavit duly authorized and sworn thereto by each of them setting forth that at such regular annual meeting, the date and place of said meeting being stated in the affidavit, that it was voted by a two-thirds majority of its members then and there present, to amend its Articles of Incorporation as therein set forth and that the affiants are the President, Vice President and Secretary of the Association duly empowered and authorized to prepare such Amended Articles of Incorporation.

Dr. Elston moved the adoption of the amendments. The motion was seconded by Dr. E. A. Johnson and carried unanimously.

Dr. Myrabo moved that the reading of the reports of officers be dispensed with inasmuch as they appear in the Delegates Handbook. The motion was seconded by Dr. Willcockson and carried.

Dr. McDonald appointed the following Reference Committees.

Committee on Credentials — Drs. E. H. Mueller, T. H. Willcockson, M. R. Cosand.

Committee on Reports of Officers and Councilors — Drs. R. J. Foley, F. Gilbert, and C. L. Vogele.

Committee on Resolutions and Memorials — Drs. C. A. Stern, V. Janavs, and R. E. Bormes.

Committee on Reports of Standing Committees — Drs. G. Robert Bartron, R. C. Jahraus, and E. W. Sanderson.

Committee on Reports of Special Committees and Miscellaneous Business — Drs. J. A. Anderson, R. R. Giebink, Paul Hohm.

The Nominating Committee was appointed by Dr. Davidson prior to the meeting and consisted of the following physicians: William Taylor, M.D., T. J. Wrage, Jr., M.D., J. A. Muggly, M.D., R. C. Jahraus, M.D., F. Leigh, M.D., P. P. Brogdon, M.D., A. K. Myrabo, M.D., Clark F. Johnson, M.D., Reuben Bareis, M.D., E. P. Sweet, M.D., C. A. Johnson, M.D., and E. A. Johnson, M.D.

The speaker assigned the reports of officers and councilors, and committee reports to the proper reference committees.

Five resolutions had been submitted to the House of Delegates for consideration. They are as follows.

RESOLUTION #1

WHEREAS the freedom of individual choice is gradually giving way to the increasing control of the social planners.

BE IT RESOLVED that this organization is opposed to the legislation presently before the Congress of the United States which would offer funds for establishing further Federal aid and control to Medical Schools and to Mental Health Centers throughout the country. This is another move to gain a foothold in the control of medical practice and buy the votes of another segment of the population. Such problems, if they exist, are the responsibility of individual citizens, communities, and states.

7th District Medical Society

RESOLUTION #2

WHEREAS: The Board of Medical Examiners has had under consideration several cases involving moral turpitude on the part of physicians, and

WHEREAS: Although the Board of Medical Examiners has the legal responsibility of dealing with problems of this sort when they come to the attention of the Board; steps could be taken by local practitioners and hospital staffs prior to the time it would be necessary to report such situations to the Board.

NOW, THEREFORE, BE IT RESOLVED that the House of Delegates of the South Dakota State Medical Association urge all of its members individually, and as hospital staffs or local medical societies, to investigate and to give every assistance possible to individuals who, without help, might become involved in disciplinary action by the Board.

RESOLUTION #3

WHEREAS the Black Hills District Medical Society recognizes the usefulness of group hospitalization insurance plans, and

WHEREAS a substantial number of members of this District Society have expressed interest in such a plan,

We hereby instruct our delegates to the 1963 Annual Meeting of the South Dakota State Medical Association to explore the possibility of establishing one or more group hospitalization plans through the State Medical Association.

Ninth District Medical Society

RESOLUTION #4

Introduced by Dr. G. R. Bartron of Watertown, District II on June 8, 1963.

WHEREAS, the South Dakota Physician's Committee was organized more than three years ago by South Dakota Physicians and has been continuous in its activity since that time,

AND WHEREAS, its accomplishments have been noteworthy during that period in educating the public regarding proposed health care legislation, and in arousing physicians to their responsibilities in the field of political interest, activity, and support,

THEREFORE, BE IT RESOLVED THAT, the House of Delegates of the South Dakota State Medical Association commends the South Dakota Physician's Committee for the effective efforts it has exerted in the political events of the past three years, for its work in educating the public regarding proposed health care legislation and for its activities in stimulating physicians to devote more of their time, efforts, and financial support to political affairs,

AND BE IT FURTHER RESOLVED THAT, this House of Delegates urges the members of our association to join the South Dakota Physician's Committee to contribute of their time, effort, and financial support to its program.

RESOLUTION #5

Introduced by Dr. G. R. Bartron of Watertown, District II on June 8, 1963.

WHEREAS, the American Medical Political Action Committee (AMPAC) has been organized and functioning on a national level in the field of political education and action,

AND WHEREAS, the purposes of this organization are to stimulate, direct, and consolidate the efforts of individual physicians and the profession generally in the field of political education and action,

BE IT RESOLVED THAT, the House of Delegates of the South Dakota State Medical Association hereby endorses AMPAC and its activities and purposes,

AND BE IT FURTHER RESOLVED THAT, the House of Delegates urges members of the South Dakota State Medical Association to become members of AMPAC and to devote time, effort, and financial support to assist in its activities.

They were referred to the Reference Committee on Reports of Special Committees and Miscellaneous Business.

Dr. Paul Hohm submitted the following resolution from the floor.

"We, the members of the Fifth District Medical Society, ask specifically that the officers of the State Medical Association condemn the glamorous advertising of cigarette smoking.

Furthermore, we recommend that a news item be released discouraging High School students from initiating the smoking habit, and that the Association go on record as accepting the fact that cigarette smoking is detrimental to health."

The resolution was referred to the Reference Committee on Reports of Special Committees and Miscellaneous Business.

Dr. T. J. Wrage, Jr. submitted the following resolution from the floor.

"Whereas, the South Dakota Medical Association commends and approves the principle of voluntary health agencies, and

Whereas, it is a firm belief of the South Dakota Medical Association that these agencies contribute a creditable service to the communities of our state, and

Whereas, the South Dakota State Medical Association in its considered opinion believes that these agencies should be free to conduct their own programs of research, public and professional education, and fund raising in their particular spheres of interest,

Now Therefore Be It Resolved, that the South Dakota State Medical Association supports the independent fund raising drives of the charitable health organizations and opposes the methods and principles of united health fund drives.

This resolution was also referred to the Reference Committee on Reports of Special Committees and Miscellaneous Business.

Dr. Myrabo nominated Dr. H. P. Volin for honorary life membership in the Association. The nomination was seconded by Dr. Sanderson and carried.

Dr. Elston nominated Dr. Frieda Radusch for honorary life membership in the Association. The nomination was seconded by Dr. Blunck and carried.

Dr. McDonald introduced Dr. Arthur A. Lampert who spoke on the national legislative scene and explained the AMA's position on pending legislation.

Mr. Charles Johnson of the AMA's Field Staff spoke on "Operation Hometown" and a movie with Dr. Edward Annis explaining the program was shown.

A letter from the AMA's Council on Medical Service was read commending Dr. H. Russell Brown for his work as chairman of the AMA's Committee on Prepayment and Insurance.

Mr. Foster announced the meeting places of the reference committees and also the schedule for Sunday's events.

Dr. Perry moved that the meeting be adjourned at 8:40 P.M. The motion was seconded by Dr. Brogdon and carried.

SECOND HOUSE OF DELEGATES MEETING

Ho-Ti Room Kochi Motel
Yankton, South Dakota
June 9, 1963

The second meeting of the House of Delegates was called to order by Dr. C. J. McDonald, Speaker of the House, at 2:15 P.M., Sunday, June 9, 1963. The following members were present for roll call: Drs. Magni Davidson, R. H. Hayes, J. Patrick Steele, A. P. Reding, C. J. McDonald, E. J. Perry, J. J. Stransky, M. C. Tank, L. C. Askwig, Paul Hohm, Preston Brogdon, T. H. Sattler, J. T. Elston, E. P. Sweet, H. E. Lowe, E. A. Johnson, C. L. Vogele, R. E. Bormes, G. Robert Bartron, W. T. Sweeney, T. J. Wrage, Jr., Donald Scheller, J. A. Anderson, R. C. Jahraus, H. Werthmann, F. D. Leigh, E. H. Mueller, C. F. Binder, Robert Giebink, Jack Donahoe, G. M. Jameson, A. K. Myrabo, E. W. Sanderson, Robert Quinn, T. A. Angelos, R. J. Foley, T. H. Willcockson, S. F. Sherrill, R. Bareis, T. Jacobson, F. Gilbert, C. F. J. Blunck, M. R. Cosand, C. A. Johnson, and V. Janavs.

Dr. Sweet read the report of the Nominating Committee.

The Nominating Committee submitted the name of Dr. M. C. Tank as Councilor from the Third District Medical Society. Dr. Davidson moved that nominations cease and that a unanimous ballot be cast for Dr. Tank. The motion was seconded by Dr. Elston and carried.

The Nominating Committee submitted the name of Dr. Paul Hohm as Councilor from the Fifth District Medical Society. Dr. Perry moved that nominations cease and that a unanimous ballot be cast for Dr. Hohm. Dr. Bareis seconded the motion and it was carried.

The Nominating Committee submitted the name of Dr. Preston Brogdon as Councilor from the Sixth District Medical Society. Dr. Perry moved that nominations cease and that a unanimous ballot be cast for Dr. Brogdon. The motion was seconded by Dr. Bormes and carried.

The Nominating Committee submitted the name of Dr. E. T. Lietzke as Councilor from the Seventh District Medical Society. Dr. Myrabo moved that nominations cease and that a unanimous ballot be cast for Dr. Lietzke. The motion was seconded by Dr. Sanderson and carried.

The Nominating Committee submitted the name of Dr. James Patrick Steele for the office of President Elect. Dr. Tank moved that nominations cease and that a unanimous ballot be cast for Dr. Steele. The motion was seconded by Dr. Reding and carried.

The Nominating Committee submitted the names of Dr. Preston Brogdon and Dr. Paul Hohm for the office of Vice President. A written ballot was cast for this office and Dr. Paul Hohm was elected, by a vote of 27-15.

The Nominating Committee submitted the names of Dr. Donald Scheller and Dr. Robert Giebink for the office of Speaker of the House. A written ballot was cast for this office and Dr. Giebink was elected. The vote was 33-7, with 2 not voting.

The Speaker then asked for nominations from the floor to fill the vacancy of Councilor from the Fifth District Medical Society for a three year term because of Dr. Hohm's election to the Vice Presidency. Dr. Perry nominated Dr. Fred Leigh of Huron. Dr. Tank moved that nominations cease and that a unanimous ballot be cast for Dr. Leigh. The motion was seconded by Dr. Askwig and carried.

The Nominating Committee submitted the City of Sioux Falls as the site for the 1964 annual meeting; Watertown for the 1965 meeting; and Huron for the 1966 meeting. Dr. Elston moved that the House of Delegates adopt this section of the report. The motion was seconded by Dr. Hayes and carried.

Dr. Sweet moved that the report, as a whole, be adopted. The motion was seconded by Dr. Cosand and carried.

Dr. Mueller read the report of the Reference Committee on Credentials.

REPORT OF THE REFERENCE COMMITTEE ON CREDENTIALS

The Credentials of the Delegates to the South Dakota State Medical Association were checked and the following delegates, alternate delegates, officers, and councilors were present: Drs. C. L. Vogele, R. E. Bormes, G. F. McIntosh, W. T. Sweeney, G. Robert Bartron, T. J. Wrage, Jr., Donald Scheller, J. A. Anderson, R. C. Jahraus, H. Werthmann, C. S. Swanson, F. D. Leigh, Yale Charbonneau, E. H. Mueller, C. F. Binder, R. Giebink, J. Donahoe, G. M. Jameson, A. K. Myrabo, E. W. Sanderson, C. A. Stern, S. M. Brzica, T. A. Angelos, Bill Church, R. J. Foley, T. H. Willcockson, R. Bareis, T. Jacobson, F. Gilbert, C. J. Blunck, M. R. Cosand, C. A. Johnson, V. Janavs, Magni Davidson, R. H. Hayes, A. P. Reding, C. J. Mc-

Donald, R. H. Quinn, E. J. Perry, J. J. Stransky, M. C. Tank, L. C. Askwig, Paul Hohm, Preston Brogdon, E. T. Lietzke, T. H. Sattler, J. T. Elston, E. P. Sweet, and E. A. Johnson.

A quorum was present for the meeting of the House of Delegates and the Credentials of those in attendance were in order.

Total registration for the convention was 394, including 195 physicians, 50 guests, 74 exhibitors, and 75 Auxiliary Members.

Respectfully submitted,
REFERENCE COMMITTEE ON CREDENTIALS,
E. H. Mueller, M.D.
T. H. Willcockson, M.D.
M. R. Cosand, M.D.

Dr. Brogdon moved that the report be adopted. The motion was seconded by Dr. Sweeney and carried.

Dr. Foley read the report of the Reference Committee on Reports of Officers and Councilors.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND COUNCILORS

The Committee on Reports of Officers and Councilors met and reviewed the reports as printed in the Delegates Handbook. It was noted that reports of Districts 10 and 11 were missing. The Committee feels that the officers and councilors did an outstanding job during the past year and that the appreciation of the House of Delegates should be extended to them. Each report was reviewed and it is the recommendation of the Committee that the reports be accepted. I move the adoption of this report.

Respectfully submitted,
REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND COUNCILORS
R. J. Foley, M.D., Chairman
C. L. Vogele, M.D.
F. Gilbert, M.D.

Dr. Foley moved the adoption of the report. The motion was seconded by Dr. Vogele and carried.

Dr. Bareis discussed the reorganization of committees suggested in the Executive Secretary's report. Dr. Sattler moved that this matter be referred to the Council for further study. The motion was seconded by Dr. Bareis and carried.

The report of the Reference Committee on Resolutions and Memorials was read by Dr. R. E. Bormes.

REPORT OF THE REFERENCE COMMITTTEE ON RESOLUTIONS AND MEMORIALS

WHEREAS, the Yankton District Medical Society and the Ladies Auxiliary members have been so thorough in making arrangements for the success of the combined meeting of our 82nd Anniversary.

BE IT RESOLVED, that the South Dakota State Medical Association give its voice in appreciation and thanks to the local physicians in Yankton and their wives.

WHEREAS, the management of the Kochi Motel, Skyline Motel and the Charles Gurney Hotel have been so cooperative in providing facilities for the success of the 82nd Anniversary meeting of the South Dakota State Medical Association.

BE IT RESOLVED, that the South Dakota State Medical Association extend its thanks and appreciation to the Kochi Motel, Skyline Motel, and the Charles Gurney Hotel.

WHEREAS, the Chamber of Commerce has provided excellent service in making it possible for the success of the working arrangements.

BE IT RESOLVED, that the South Dakota State Medical Association extend its thanks and appreciation to the Yankton Chamber of Commerce.

WHEREAS, The Yankton Press and Dakotan and Radio Station WNAX have been most cooperative in presenting the public news of the 82nd annual meeting of the South Dakota State Medical Association.

BE IT RESOLVED, that the South Dakota State Medical Association extend its thanks to the Yankton Press and Dakotan and radio station WNAX.

WHEREAS, the Hillcrest Country Club of Yankton has provided facilities for the Stag Party and contributed much to the success of the Meeting and entertainment.

BE IT RESOLVED, that the South Dakota State Medical Association extend its thanks to the Hillcrest Country Club of Yankton.

WHEREAS, the Black Steer Restaurant has provided facilities for the banquet and contributed much to the success of the meeting and entertainment.

BE IT RESOLVED, that the South Dakota State Medical Association extend its thanks to the Black Steer Restaurant.

BE IT RESOLVED, that the South Dakota State Medical Association donate $50.00 in memory of each of the five member physicians who passed away during the past year, to the South Dakota Medical School Endowment Association.

Respectfully submitted,
COMMITTEE ON RESOLUTIONS AND MEMORIALS
C. A. Stern, M.D., Chairman
R. E. Bormes, M.D.
V. Janavs, M.D.

Dr. Bormes moved the adoption of the report. The motion was seconded by Dr. Tank and carried.

Dr. G. Robert Bartron read the report of the Reference Committee on Standing Committees.

REPORT OF THE REFERENCE COMMITTEE ON STANDING COMMITTEES REPORTS

REPORT OF THE COMMITTEE ON SCIENTIFIC WORK

We recommend the acceptance of this report.

REPORT OF THE COMMITTEE ON LEGISLATION

We recommend the acceptance of the committee's report and recommend that individual physicians cooperate in supporting the actions of the Legislative Committee with respect to opposition to the King-Anderson Bill, and participate in the "Operation Home Town" program of the A.M.A.

REPORT OF THE PUBLICATIONS COMMITTEE

We recommend the acceptance of this report.

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

We recommend the acceptance of this report, and the Reference Committee further recommends that the Committee on Medical Defense and the Medical-Legal Conference Committee be combined and the function of the combined committee then be explained to the members of the Association.

REPORT OF THE COMMITTEE ON MEDICAL SCHOOL AFFAIRS, MEDICAL EDUCATION AND HOSPITALS

We recommended the acceptance of this report.

REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

We recommend the acceptance of this committee's report, and the Reference Committee has noted, however, that the Council has endorsed a second loss of time insurance coverage which the Committee on Medical Economics had not reviewed prior to the Council's endorsement.

REPORT OF THE COMMITTEE ON NECROLOGY

We recommend the acceptance of this report, and the Reference Committee respectfully requests of the House of Delegates that the name of the committee be changed to the Committee on Physicians' Obituaries.

REPORT OF THE COMMITTEE ON PUBLIC HEALTH

We recommend the acceptance of this report, and the Reference Committee recommends that a mem-

ber of the State Public Health Advisory Committee of Public Health for the State of South Dakota be included in this committee, as is presently the case.

REPORT OF THE COMMITTEE ON CANCER

We recommend the acceptance of this report.

REPORT OF THE COMMITTEE ON TUBERCULOSIS

The Reference Committee recommends the acceptance of this report, and commends the committee on their long hours in working with the Legislative Research Council.

REPORT OF THE COMMITTEE ON MATERNAL AND CHILD WELFARE

We recommend the acceptance of this report.

REPORT OF THE EXECUTIVE COMMITTEE

We recommend the acceptance of this report.

REPORT OF THE GRIEVANCE COMMITTEE

We recommend the acceptance of this report.

REPORT OF THE BENEVOLENT FUND COMMITTEE

We recommend the acceptance of this report.

REPORT OF THE COMMITTEE ON RHEUMATIC FEVER AND HEART DISEASE

We recommend the acceptance of this report. The Reference Committee feels that the existence of this assistance may not generally be known and recommends that all the members of the Association take note of it.

Respectfully submitted,
REFERENCE COMMITTEE ON
REPORTS OF STANDING COMMITTEES
G. Robert Bartron, M.D., Chairman
R. C. Jahraus, M.D.
E. W. Sanderson, M.D.

Dr. Bartron moved the adoption of the report. The motion was seconded by Dr. Reding and carried.

Dr. Robert Giebink read the report of the Reference Committee on Special Committees and Miscellaneous Business.

REPORT OF THE REFERENCE COMMITTEE ON SPECIAL COMMITTEES AND MISCELLANEOUS BUSINESS

The Reference Committee has considered the report of the Committee on Radio Broadcasts and Telecasts and recommends the adoption of this report.

The Reference Committee has considered the report of the Committee on AMEF and recommends the adoption of this report.

The Reference Committee has considered the report of the Editorial Committee and recommends the adoption of this report.

The Reference Committee has considered the report of the Committee on Medical Licensure and recommends the adoption of this report.

The Reference Committee has considered the report of the Committee on Veterans Administration and Military Affairs and recommends acceptance of this report.

The Reference Committee has considered the report of the Spafford Memorial Fund Committee and recommends acceptance of this report.

The Reference Committee has considered the report of the Committee on Prepayment and Insurance Plans and recommends the acceptance of this report.

The Reference Committee has considered the report of the Committee on Rural Health and recommends acceptance of this report.

The Reference Committee has considered the report of the Committee on Nurses Training and recommends acceptance of this report.

The Reference Committee has considered the report of the Committee on Workmen's Compensation. The Committee recommends that legislation be introduced at the next session of the legislature providing for the appointment of the Industrial Commissioner for a six year term by the governor, with adequate compensation, in order to secure continuity of the Department and to better formulate changes to improve the Workmen's Compensation law. The Committee approves the report of this committee with the above recommendation and recommends acceptance of the report.

The Committee has considered the report of the Committee on Clinical Pathology and recommends acceptance of the report.

The Committee has considered the report of the Committee on Rehabilitation and recommends the acceptance of this report.

The Committee has considered the report of the Committee on Press Radio and recommends the acceptance of the report.

The Committee has considered the report of the Committee on Care of the Indigent and recommends acceptance of the report.

The Committee has considered the report of the Committee on Civil Defense and recommends acceptance of the report.

The Committee has considered the report of the Committee for Improvement of Patient Care and recommends the acceptance of this report.

The Committee has considered the report of the Committee on School Health and recommends the acceptance of this report.

The Committee has considered the report of the Committee on Budget and Audit. The committee recommends the acceptance of the budget as approved by the Council without change.

The Committee has considered the report of the Committee on Aging and recommends the acceptance of this report.

The Committee has considered the report of the Committee on Coroner's Law and recommends the acceptance of this report.

The Committee has considered the report of the Committee on Traffic Safety and recommends the acceptance of this report.

The Committee has considered the report of the Medical-Legal Conference Committee and recommends the acceptance of this report.

The Committee has considered the report of the Liaison Committee with the Pharmaceutical Association and recommends the acceptance of this report.

The Committee has considered Resolution #1 introduced by the 7th District Medical Society, a copy of which you have, concerning opposition to Federal programs. While the Committee is in agreement with the general intent of such a resolution, it was felt that the resolution was not specific enough to warrant adoption, and therefore the Committee recommends that it not be adopted.

I move the adoption of this portion of the report.

The Committee has considered Resolution #2, a copy of which you have, concerning responsibility of physicians in the State in assisting the Board of Medical Examiners in dealing with problems with physicians arising in the State before Board action is necessary. The Committee recommends that this resolution be adopted.

I move the adoption of this portion of the report.

The Committee has considered Resolution #3, introduced by the Black Hills District Medical Society, a copy of which you have, concerning a state-wide Blue Cross-Blue Shield group for physicians and the office personnel. The Committee recommends that this resolution be adopted.

I move the adoption of this portion of the report.

The Committee has considered Resolution #4, introduced by the Watertown District Medical Society, a copy of which you have, endorsing and commending the work of the South Dakota Physician's Committee. The Committee recommends adoption of this resolution.

I move the adoption of this portion of the report.

The Committee has considered Resolution #5, introduced by the Watertown District Medical Society, a copy of which you have, endorsing and commending the work of the American Medical Political Action Committee. The Committee recommends adoption of this resolution.

I move the adoption of this portion of the report.

The Committee has considered Resolution #6, introduced by the Huron District Medical Society, a copy of which you have.

The Committee recommends the elimination of the first paragraph, and approval of the second paragraph as submitted.

I move the adoption of this portion of the report.

The Committee has considered Resolution #7, introduced by the Watertown District Medical Society, concerning United Funds, a copy of which you have.

The Committee recommends that this resolution not be adopted.

I move the adoption of this portion of the report.

The Reference Committee on Reports of Special Committees and Miscellaneous Business, having considered resolutions in opposition to King-Anderson type legislation, and feeling that reference should also be made to the Kerr-Mills legislation which was passed by the Legislature at the 1963 session, proposes the following resolution:

WHEREAS: The Council and the House of Delegates has endorsed in principle the implementation of the Kerr-Mills law in the area of medical aid to the aging, and

WHEREAS: the officers and staff of the Association and members of the Legislature have studied and prepared legislation which became law in March of 1963, and

WHEREAS: the Association desires to recognize the specific achievement which resulted from these efforts,

NOW, THEREFORE BE IT RESOLVED: That the South Dakota State Medical Association wholeheartedly endorses the legislation adopted by the 1963 Legislature and further recognizes and endorses the method of operation adopted by the State agency having responsibility for operation of the program.

The Committee recommends adoption of this portion of the report.

I move the adoption of this portion of the report.

I move the adoption of the report as a whole.

Respectfully submitted,

REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES AND MISCELLANEOUS BUSINESS
J. A. Anderson, M.D., Chairman
Robert Giebink, M.D.
Paul Hohm, M.D.

Dr. Giebink moved the adoption of the reports of the Special Committees. The motion was seconded by Dr. Blunck and carried.

Dr. Giebink read the recommendation of the Reference Committee on Resolution #1 concerning opposition to Federal programs. (Refer to Minutes of First House Meeting.) Dr. Giebink moved the adoption of this portion of the report. The motion was seconded by Dr. Bormes and carried.

Dr. Giebink read the recommendation of the Reference Committee on Resolution #2 concerning the Board of Medical Examiners. (Refer to Minutes of First House Meeting). Dr. Giebink moved the adoption of this portion of the report. The motion was seconded by Dr. Elston and carried.

Dr. Giebink read the recommendation of the Reference Committee on Resolution #3 concerning a State wide Blue Cross-Blue Shield group for physicians and office personnel. (Refer to Minutes of First House Meeting). Dr. Giebink moved the adoption of this resolution. The motion was seconded by Dr. Bareis and carried.

Dr. Giebink read the recommendation of the Reference Committee on Resolution #4 (Refer to Minutes of First House Meeting) concerning endorsement of the South Dakota Physicians Committee. Dr. Giebink moved that this Resolution be adopted. The motion was seconded by Dr. Angelos and carried.

Dr. Giebink read the recommendation of the Reference Committee on Resolution #5 (Refer to Minutes of First House Meeting) concerning endorsement of the American Medical Political Action Committee. Dr. Giebink moved that this resolution be adopted. The motion was seconded by Dr. Cosand and carried.

Dr. Giebink then read the resolution introduced by the Fifth District Medical Society concerning smoking as follows:

The Committee recommended that the first paragraph be eliminated and that approval be given to the second paragraph as submitted. Dr. Giebink moved the adoption of this section of the report. The motion was seconded by Dr. Tank. Dr. Donahoe moved that the paragraph be amended to read as follows: "The South Dakota State Medical Association endorses the position of the American Heart Association and the American Cancer Society on the effects of tobacco on the human body and recommends to the youth of the State that they abstain from adopting the smoking habit because of known and potential physical dangers." The amendment was seconded by Dr. Sattler and carried. The resolution as amended was then carried.

Dr. Giebink read the recommendations of the Reference Committee on Resolution #7 introduced by T. J. Wrage, Jr., M.D., concerning the United Fund drives. (Refer to Minutes of First House Meeting). Dr. Giebink moved the adoption of this portion of the report. The motion was seconded by Dr. E. A. Johnson and carried.

Dr. Giebink read the resolution concerning endorsement of Kerr-Mills legislation.

Dr. Giebink moved the adoption of this resolution. The motion was seconded by Dr. Sanderson and carried.

Dr. Giebink moved the adoption of the report in its entirety. The motion was seconded by Dr. Reding and carried.

Dr. McDonald introduced the new officers of the State Association.

Dr. McDonald administered the Presidential Oath of Office to Dr. Robert H. Hayes, the incoming president of the Association for the next year.

Dr. McDonald made a few announcements concerning the scientific sessions to be held on Monday and Tuesday.

Dr. McDonald then introduced Dr. G. J. Van Heuvelen who spoke on the proposed vaccination program in South Dakota and the TB Control program to be inaugurated in July.

Dr. Bartron moved that the House of Delegates accept the decision of the Council not to endorse the vaccination program proposed by the Federal government. The motion was seconded by Dr. Hohm and carried.

Dr. Quinn moved that the matter of the TB Control Program be referred to the Committee on Tuberculosis for action, giving that committee the power to act on the decisions they reach. The motion was seconded by Dr. Mueller and carried.

Dr. Sanderson moved that the Committee on Tuberculosis be instructed to survey all hospitals who agree to participate in the program; that the physicians on these hospital staffs who agree to participate in the care of these patients be surveyed and their credentials checked to ascertain that they are qualified to care for the patients; that the names be given to Dr. Van Heuvelen as soon as possible. The motion was seconded by Dr. Bartron and carried.

The meeting adjourned on motion at 4:30 P.M.

PRESIDENTIAL OATH OF OFFICE

I solemnly swear that I shall carry out the duties of the President of the South Dakota State Medical Association to the best of my ability. I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving health standards and to the task of bringing increasingly improved medical care to the people of South Dakota. I shall uphold the Constitution and Bylaws of the AMA and the South Dakota State Medical Association. I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans.

I do solemnly swear that I will discharge the duties of this office to the best of my ability, so help me God.

REPORTS OF OFFICERS AND COUNCILORS AS ADOPTED BY THE HOUSE OF DELEGATES

REPORT OF THE PRESIDENT

During the past year, it has been my pleasure to serve as your President. I have been able to attend approximately 2/3 of the district meetings, and at each meeting I was accorded much kindness and respect.

Much of the work this year centered around the MAA program for South Dakota, and although some of the more routine matters of the presidency had to be laid aside in order that the MAA program could be put into effect, it was a very gratifying experience to spend the time that was needed in order to help initiate the program.

I was present for the first three days of the legislative session, and I attended the AMA session in Chicago. During the conference I had the pleasure of hearing Dr. Edward Annis speak, and I can assure you that the AMA will be in excellent hands during Dr. Annis's term as president. I attended two special meetings in Pierre, both regarding the proposed MAA (Kerr-Mills) program for South Dakota. I certainly feel that the time and effort was well spent inasmuch as the Kerr-Mills law will go into effect on July 1, in South Dakota, with our own organizations of Blue Shield and Blue Cross acting as the insurance carrier for the program. It might be noted that South Dakota is the first State to adopt a Kerr-Mills program, using an insurance approach.

I want to thank you all for the privilege of serving as your president during the past year and I extend my congratulations to the incoming president, Dr. Hayes.

Respectfully submitted,
Magni Davidson, M.D.
President

The Reference Committee recommends the acceptance of this report.

REPORT OF THE PRESIDENT-ELECT

Since my return to Civilian life, I have found that the paper work is becoming nearly as great as in the Military. The requests for insurance forms, letters of reference etc. continue to mount in increasing quantity. This, I am sure all physicians even in our rural State of South Dakota are well aware of. To make matters worse, I can see no possible solution for changing the tide.

The Council meetings in September and January were attended and it was noted that a sinister cloud of law suits against physicians was becoming greater as the reports of the Council would indicate. It might be well for all of us to re-read the many articles on how to avoid the law suits with the hope that we might be able to do so.

Other major items of business which seemed to occupy the greater amount of time was the meeting with the Welfare group in Pierre to iron out the problems of OAA, and more recently, the meeting in April of the MAA program. It is certainly interesting to note that our State Association has proposed an insurance plan as a pilot study. Whether or not it will work, of course, will depend on all physicians in our Association, but I am confident that it will, knowing them as I do. I hope that this in turn will help stave off the grim specter of a social security medical plan such as President Kennedy proposed.

The legislative session brought forth some special problems which only again reflects the ever growing idea that physicians are considered too powerful and that the public wishes that power reduced. My own impression is that the public is wrong and that we are not that powerful, but I can see how they would feel that way. It will be interesting to see if we can maintain our own solidarity and still not have the public feel that this is a bad thing and is not being used other than for the benefit of our patients.

In my letter the past year, I made reference to the fact that the medicine the Army practiced not being good, and some of my military friends promptly took issue with this. I have written to them and apologized and I should do so to this Association because I did not wish to say that any of them did not practice good medicine, but I had merely meant to say that which they practiced was strictly impersonal medicine. Furthermore, it would be not impersonal to those physicians but, rather, to the patient. I hope that I have made this clear.

Respectfully submitted,
Robert H. Hayes, M.D.
President-Elect

The Reference Committee recommends the acceptance of this report.

REPORT OF THE VICE PRESIDENT

During the last year the Vice President has been assigned no particular duties other than participation in the deliberations of the Council. There have been no particular problems or unusual occurrences during the past year that have directly affected the office of Vice President. The officers and members of the Society are to be commended for their efforts during the session of the State Legislature.

Respectfully submitted,
James P. Steele, M.D.
Vice President

The Reference Committee recommends the acceptance of this report.

REPORT OF THE SECRETARY-TREASURER

As your officer, I have attended all Executive Committee and Council Meetings during the year. The duties of my office were carried out with the cooperation of our able and competent Executive Secretary, John C. Foster, and the entire headquarters staff.

Respectfully submitted,
A. P. Reding, M.D.
Secretary-Treasurer

The Reference Committee recommends the acceptance of this report.

REPORT OF THE ALTERNATE DELEGATE TO THE AMA

I attended the 111th annual meeting of the AMA in Chicago, Illinois, June 24-28, and the 16th Clinical Meeting in Los Angeles, California, Novem-

ber 25-28. Since your delegate, Dr. A. A. Lampert, was unable to attend the meeting in Los Angeles, I served as your Delegate. Reports of these meetings appeared in the AMA News and AMA Journal, and were published in the **South Dakota Journal of Medicine and Pharmacy.**

This is my last report as your alternate delegate; I will be serving as your delegate for the next two years. I would like to express my appreciation to Dr. Lampert for his excellent "tutoring" and advice during the eight years I served as his alternate. I shall strive to do the same for my alternate, Dr. Robert H. Quinn.

Respectfully submitted,
A. P. Reding, M.D.
Alternate Delegate to the AMA

The Reference Committee recommends the acceptance of this report.

REPORT OF THE SPEAKER OF THE HOUSE

No report.

Respectfully submitted,
C. J. McDonald, M.D.
Speaker of the House

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR-AT-LARGE

As Councilor-at-Large, I have attended all meetings of the Council during the past year. This has constituted my primary duties as Councilor-at-Large.

Respectfully submitted,
C. J. McDonald, M.D.
Councilor-at-Large

The Reference Committee recommends the acceptance of this report.

REPORT OF THE EXECUTIVE SECRETARY

The executive office has continued its program of service to physicians during the fiscal year 1962-1963. Personnel changes during the year saw assistant executive secretary Phyllis Sundstrom become Mrs. Ronald Lockwood in August, and in December she left the Association to be a full-time housewife. Richard C. Erickson was promoted from field secretary to Assistant Executive Secretary and Mrs. Clark Butler (Patty) became Administrative Assistant.

Public Relations

The Speaker's Bureau, formed the year before, provided speakers for over forty speaking engagements, not including those presented by the executive secretary.

The executive office provided advertising mats for local societies which were used for educational purposes re medical care for the aged.

The executive secretary spoke on Medical Care for the Aged to 33 groups totalling 1,160 people. He spoke to five groups totalling 325 people on other subjects, and made one TV appearance on the KELO-Land stations.

The executive office worked closely with local societies on the Oral Polio Vaccine Clinics and served as the clearing house for the very successful programs in the Sioux Falls area which vaccinated 100,000 South Dakotans.

Headquarters Building

During the year we paid all the interest due physicians and retired $3,278.19 in notes. The problem of tax exemption has not been cleared as yet but the matter has been turned over to a firm of attorneys who will have more time to handle the matter than the previous firm.

Liaison With District Societies

The executive secretary, during the year, attended 10 District Society meetings but managed to visit only 6 different societies. He visited the Black Hills Society and Madison-Brookings three times each; and Yankton, Sioux Falls, Mitchell, and Winner once each. Mr. Erickson visited five District meetings in Sioux Falls, Huron, Brookings, Yankton and Rapid City.

Committee Work

Inasmuch as the Association is basically a committee organization, the executive office spends much of its time working with those committees in carrying out their duties. Because of time and distance limitations, several meetings were held by use of conference telephone. In all, staff people attended 32 committee meetings not counting those at the Annual Meeting.

Liaison With Other Groups

As in the past the executive office has represented the Association in dealings with a variety of voluntary and governmental agencies. It is the firm belief of the executive secretary that while attendance at many of these sessions is time-consuming and often fruitless, that to reduce this activity would decrease the general effectiveness of the Association.

The role of the executive secretary in these liaison, committee, public relations, and other association functions as well as Blue Shield caused him to roll up in excess of 50,000 miles of travel. Mr. Erickson chalked up another 22,000.

Blue Shield and Other Fiscal Programs

The fiscal programs set up by the association and operated under the banner of Blue Shield have continued their steady growth. In April of 1961, Blue Shield had 15,000 contracts in force; in 1962, 18,000; and this year close to 20,000. Earned income has increased from $435,000.00 in 1961 to $655,000.00 in 1962, to $750,000.00 in 1963. During the year, South Dakota Blue Shield paid physicians $618,000.00 in claims. Old Age Assistance, which has smoothed out considerably from its earlier operation, paid physicians $317,000.00 and Medicare (Army-type) paid $56,860.00. All in all, Blue Shield paid physicians in South Dakota just under one million dollars last year.

The Journal

After a disastrous year financially in 1961, The Journal broke even in 1962 and began to pay off its losses in 1963. New advertising regulations out of Washington may slow the rate of return-to-normal but we should continue to do a little better than break even.

Mrs. Judee Schlosser has gone on part-time employment with the Journal, thus reducing overall costs.

Recommendations

The executive secretary would like to commend his office staff for their excellent work during the year and also the hard-working executive committee who gave freely of their time during legislative session and in discussions with the Welfare Department.

After careful consideration the executive secretary would like to recommend that:

1. A study be made of the Committee structure of the Association, particularly the special committees, with an eye to streamlining and combining functions.
2. That a special committee on Public Relations be formed to outline general and specific programs of public relations.

Respectfully submitted,
John C. Foster
Executive Secretary

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCIL

There were three regular meetings held during the year, in June, September, and January. The minutes of each of these meetings have been published in the **South Dakota Journal of Medicine and Pharmacy.**

The Council took action on proposed state and national legislation; endorsed and supported the State MAA program; endorsed a second group loss-of-time program for Association members; studied the proposed budget of the State Medical Association; recommended that local District Medical Societies carry out oral polio vaccination programs; and considered many matters of miscellaneous business presented to it.

Respectfully submitted,
E. P. Sweet, M.D.
Chairman of the Council

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR FIRST DISTRICT

MEMBERSHIP: 42 Members
OFFICERS:
President, R. Berzins, M.D.
Vice President, B. C. Gerber, M.D.
Secretary-Treasurer, P. R. Leon, M.D.
COUNCILOR:
E. J. Perry, M.D.
CENSORS:
B. F. King, M.D.
J. Calene, M.D.
C. L. Vogele, M.D.
DELEGATES:
W. R. Taylor, M.D.
C. L. Vogele, M.D.
R. E. Bormes, M.D.
ALTERNATES:
G. J. Bloemendaal, M.D.
G. F. McIntosh, M.D.
Carson Murdy, M.D.

The Aberdeen District Medical Society holds monthly dinner meetings on the first Wednesday of each month from September to June. The following is a list of speakers:

September: Dr. Noel de Dianous, Jr. of Aberdeen spoke on "Tuberculosis in Children."

October: Dr. Robert Stoltz of Minneapolis spoke on "Electro encephalography and Its Clinical Applications."

November: Dr. Walter L. Hard, Dean of the South Dakota Medical School spoke on "Recruitment of Medical Students."

December: The Aberdeen District Annual election of Officers and business meeting was held.

January: A paper on "Medical Malpractice Insurance" was presented by Mr. S. Siegel, Aberdeen Lawyer.

February: Dr. B. C. Gerber presented a paper on "Hereditary Pancreatitis — The Role of Surgical Intervention."

March: Dr. Paul McCarthy presented an illustrated discussion on "Carcinoma of the Uterine Cervix."

April: Dr. W. T. Sweeney, Pathologist at St. Luke's Hospital, spoke on "Gross Pathology of Common Lesions of the Female Reproductive Tract."

The visitation from Dr. Magni Davidson, President of the South Dakota State Medical Association, was cancelled due to weather.

May: Dr. W. H. Karlins, Webster Clinic, spoke on "Useful Procedures in Treatment of Certain Fractures."

Respectfully submitted,
E. J. Perry, M.D., Councilor
First District

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR SECOND DISTRICT

MEMBERSHIP: 23 Members
OFFICERS:
President, Gerald E. Tracy, M.D.
Vice President, Valdis Brakks, M.D.
Secretary-Treasurer, Parry S. Nelson, M.D.
COUNCILOR:
John J. Stransky, M.D.
CENSORS:
Burke Brewster, M.D.
Tom Reul, M.D.
DELEGATES:
T. J. Wrage, Jr., M.D. (One year)
G. R. Bartron, M.D. (Two years)
ALTERNATES:
C. J. Clark, M.D.
Parry S. Nelson, M.D.

The Watertown District Medical Society holds monthly dinner meetings on the first Tuesday of each month from September to June. In addition to the regular business meetings, the following scientific programs were presented during the year:

October: Dr. Bell of Chicago spoke on hand surgery.

February: Mr. Ben Diamond and Mr. Norman Bredeson of the State Lab, presented a program on venereal disease.

April: Dr. Heinrichs of Watertown presented a program on the use of Vitamin 'K' in newborns.

The Watertown District Medical Society has continued its participation in several well-established programs of providing medical service to the community. These programs include the school immunization program, evaluation of all participants in school athletics, as well as others. In addition to these projects, the district, this year, participated in three programs which were of value from a medical standpoint as well as a public relations standpoint. These programs were:

1. Organization and conduction of oral polio clinics throughout the district. Approximately 20,000 Type I, 17,000 Type II, and 15,000 Type III polio immunizations were given.
2. The district was instrumental in initiating community participation in the Red Cross Blood Banking program.
3. The district society donated $1,000 to the South Dakota Medical School Endowment Association.

Our district notes with pride that Mrs. Rodney Stoltz of Watertown will assume the Presidency of the National Women's Auxiliary in June of this year.

Respectfully submitted,
John J. Stransky, M.D., Councilor
Second District

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR THIRD DISTRICT

The first meeting of this report was held at the Brookings Country Club on Thursday, June the 14th, 1962. This was the annual social meeting at which the members played golf and it was followed by a social hour and dinner and by entertainment of the men with songs. At this meeting, Chairman Roberts announced the election of our eminent member, Dr. Magni Davidson, to the office of President of the South Dakota State Medical Association. The regular business meeting was dispensed with as there was nothing of significance or urgency requiring its being held.

The next meeting of the Society was held on August the 16th, 1962, at the Madison Country Club in Madison, South Dakota. Golf was enjoyed by some of the members and after dinner, State President, Magni Davidson, gave a short address emphasizing the fact that the ensuing year would be one of political action. Following this remark by Dr. Davidson, the Executive Secretary, John C. Foster, made some remarks urging attendance to the Medical-Legal conference to be held in Sioux

Falls, September 15th. He outlined many features of the meeting, also outlined a new plan for the care of the indigent in South Dakota under OAA using Blue Cross and Blue Shield insurance. At the business meeting, the application of Dr. Homer J. Stensrud was read but the application was tabled because of the absence of the signatures of three censors and deferred until the next meeting. Following this there was a scientific, illustrated lecture by Dr. Giebink of Sioux Falls, South Dakota, on the subject "Separation of the Epiphysis of the Head of the Neck of the Femur." The meeting was then adjourned.

The third meeting of the Third District Medical Society was held on October 11th, 1962. There were 26 members present and this was held at Volga. The program consisted of recordings of interest to the members followed by a motion picture presentation of high lights of the last day of a convention in Chicago. At the business meeting the application of Homer Stensrud, M.D. was passed upon and unanimously accepted. Also, we heard a report by the Brookings, Volga and Arlington members present, that advertising copy had been placed in the local papers on the MEDICARE issue. The meeting was then adjourned.

The next meeting of the Third District Medical Society was held at Flandreau on December the 6th, 1962, at the Indian Tepee Room in Flandreau and a very fine dinner was enjoyed. A scientific lecture followed the dinner and was given by Dr. T. R. Anderson of Sioux Falls, on mediastinal cysts. This was well received by all the members. The business meeting was called to order by President Otey and John Foster, our Executive Secretary, outlined some of the legislative facts for the next session; first the proposal to close Sanator, an institution set up to eradicate tuberculosis in the State, and secondly, the implementation of the Kerr-Mills law and its operation in the State OAA program: 3. certain revisions in the law pertaining to mental health clinics. Following this, the business meeting was called and there was an election of officers for the ensuing year. The new officers are: President: Walter H. Patt, Vice-President: J. A. Anderson, Secretary-Treasurer: C. M. Kershner, Delegates: Don Scheller and J. A. Anderson, Alternates: H. R. Wold and J. A. Muggley, Censors: Drs. S. Friefeld, Roberts and Turner. The meeting was then adjourned.

The next meeting of the Third District was held at the Brookings Town Club, February 28th, 1963. Following dinner a scientific program was given by two gentlemen, Mr. Ben Diamond and Norman Radieson on "The Diagnosis of Syphilis and the Epidemiology of Venereal Disease." Following this, a business meeting was held and Dr. J. A. Muggley was proposed to serve on the State Nominating Committee and the following members were recommended for the office of councilor of the district: Drs. M. C. Tank, E. T. Otey, and J. A. Anderson. The meeting was then adjourned.

The final meeting for this year to this date was at Arlington, South Dakota, on April 18th, 1963. Following dinner at the City Cafe, there was a scientific program. Dr. W. B. Odland, ENT specialist from Huron Clinic, gave a detailed lecture on the current concepts of middle ear surgery. Following this, the business meeting was called to order by President Walter Patt, and a committee on school health was appointed. Chairman Dr. H. R. Wold, Dr. Walter Patt, Dr. Werner Klar and Dr. Scheller. Mr. John C. Foster visited again and gave us the survey of the program and entertainment features for the upcoming State Meeting at Yankton, and urged attendance. He explained that the Kerr-Mills implementation by the State Legislature was erroneously reported by the newspapers and that it was overwhelmingly approved as presented without controversy. He mentioned some of the features and advantages of the State Disability Insurance Plan presented by Combined Insurance of Chicago. Also, the status of the tax controversy in the Sioux Falls Association Building and that some of the state members from Mitchell may propose at the State meeting of the House of Delegates, a proposal for group use of Blue Cross in order to protect and lower the rates. The meeting was then adjourned. I feel that this year has been a very productive one in the Third District, and feel that one of our representatives, Dr. Magni Davidson, who is President of the State Society, has highly honored us. I must commend him on the outstanding job he has done during his presidency.

Respectfully submitted,
Myron C. Tank, M.D., Councilor
Third District

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR FOURTH DISTRICT

There were two meetings in the past year, one September 20, 1962, at the time of the visit by Dr. Lampert, and one April 18, 1963, at which time election of officers was held. The following officers were elected:

PRESIDENT:
S. W. Fox, M.D., Pierre
VICE PRESIDENT:
R. C. Jahraus, M.D., Pierre
SECRETARY-TREASURER:
J. T. Cowan, M.D., Pierre
CENSORS:
S. B. Simon, M.D., Pierre
R. J. Zakahi, M.D., Pierre
H. E. Werthmann, M.D., Pierre
DELEGATES:
R. C. Jahraus, M.D., Pierre
H. E. Werthmann, M.D., Pierre
ALTERNATE DELEGATES:
C. L. Swanson, M.D., Pierre
S. B. Simon, M.D., Pierre
RECOMMENDED FOR THE COUNCIL:
L. C. Askwig, M.D., Pierre
M. M. Morrissey, M.D., Pierre
S. W. Fox, M.D., Pierre

The Fourth District Society sponsored the Sabin Polio Clinic, and administered Type I and Type II.

Respectfully submitted,
L. C. Askwig, M.D., Councilor
Fourth District

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR FIFTH DISTRICT

The Medical Society of the Fifth District had four meetings during the year 1962-63. The meetings were all held at Huron with excellent attendance and lively participation by the members and the guests.

The first meeting on May 10, 1962, was one for handling routine matters of the Society. At this time plans were formulated for the activities and action of the Society for the coming year. The councilor discussed the coming State Meeting and was given instructions as to the opinions the Society wished to have him voice at the meeting.

The September 25th meeting was called to discuss political aspects of the coming election which was extremely pertinent. Dr. Lampert was the guest speaker. He discussed the Kerr-Mills and King-Anderson legislation and its ramification as to the effect they each have on the future of our practice of medicine. The discussion became very lively and each member present had a chance to discuss the problems. There were various opinions

voiced with good discussions following the different views.

The annual meeting with election of officers was held on December 13, 1962. Our State President was our guest speaker. Mr. Ben Diamond of the State Laboratory at Pierre, discussed the various tests and activities of the Laboratory. The election of officers was carried out with the election of the following:

President—William O. Hanson, M.D.
Vice-President—Theodore Hohm, M.D.
Secretary-Treasurer—G. M. Huet, M.D.

The last meeting was held on February 14, 1963. The problems of venereal disease were discussed by Ben Diamond and his staff. The film shown was very informative. The discussion that followed, in the form of a question and answer period, brought out many problems in this field. The attempts at solving these were further discussed. A very worthwhile and enlightening discussion ensued.

The Councilor attended all the meetings of the State Council during the year.

Respectfully submitted,
Paul H. Hohm, M.D., Councilor
Fifth District

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR SIXTH DISTRICT

Three excellent meetings were held by the Sixth District Medical Association, here in Mitchell, South Dakota.

The first meeting was held in September, 1962, at the Country Club. At this meeting, the oral polio vaccination program was initiated and a scientific meeting on arteriosclerosis was presented.

Another meeting was held January 9, 1963, at the Country Club. The Society undertook sponsorship of a social hour for the State X-Ray Technicians Convention.

The polio clinics were reported as being fairly successful in our area. Dr. George Knabe of Vermillion, South Dakota, gave a lecture on Project HOPE.

A meeting was held March 27, 1963, again at the Country Club. New officers were elected at this meeting:

President—Dr. Floyd D. Gillis
Vice President—Dr. Jack T. Berry
Secretary—Dr. Richard D. Hockett
Delegates:
Dr. Mueller
Dr. Binder
Alternates:
Dr. Porter
Dr. Monson
Councilors:
Dr. Brogdon
Dr. Frank Tobin
Dr. Lloyd, Sr.
Nomination Committee: Dr. Brogdon
The candidates were elected Unanimously.

Aid for the Aged at the State Legislation, was presented by Mr. John C. Foster. Mr. Foster also discussed the various disability, medical and surgical coverage programs available to the members of the South Dakota Medical Association, and the Sixth District Medical Society.

All in all, we have seemed to have had a successful year here in Mitchell, South Dakota.

Respectfully submitted,
Preston Brogdon, M.D., Councilor
Sixth District

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR SEVENTH DISTRICT

MEMBERSHIP: 107 Active
9 On Leave of Absence
11 Life Members

Meetings are held at the Westward Ho Country Club on the first Tuesday of each month except the summer months of June, July and August.

May 1, 1962: Meeting devoted to discussion of the combined North Dakota and South Dakota meeting to be held at Bismarck, and instructions to Delegates. First discussion regarding Oral Polio Vaccine Clinic which is to be held this fall. Unanimously voted to have the District Society sponsor and underwrite the cost of the vaccine when it becomes available in sufficient quantity to cover the area comprising the Seventh District.

September 4, 1962: A brief discussion of the United Fund Drive to be held in Sioux Falls in the near future was presented by a member of the United Fund Board.

A talk entitled "Community Building — A Job for All," was given by Mr. Gordon Olson, Secretary of the Sioux Falls Chamber of Commerce.

October 2, 1962: Doctor Julius Wilson spoke on "Current Concepts in Tuberculosis Therapy." Following the Scientific Paper, John Zimmer, Attorney for the State Medical Society, spoke on the "Physicians' Role in Politics."

November 6, 1962: This meeting was a combined meeting with the Women's Auxiliary of the Seventh District Society. There was no scientific program at this meeting.

During the business session there was considerable discussion regarding the possibility of implementation of the M.A.A. portion of Kerr-Mills Law in South Dakota. A committee was appointed by the president for the purpose of formulating principles that our district would like to have incorporated in the M.A.A. program when it becomes effective in this state.

December 4, 1962: An explanation of automation in the doctors office using I.B.M. equipment for central billing was given by a member of Nettleton Business College of Sioux Falls, and two experts from the central office in Omaha. The report of the committee on M.A.A. implementation for South Dakota was adopted and a copy of the report mailed to each District Society President.

January 8, 1963: Ben Diamond, of the State Department of Health, Pierre, discussed certain communicable disease problems with special emphasis on venereal disease reporting and control.

February 5, 1963: There was no scientific program held in February. The meeting was adjourned after the business of the Society was completed.

March 5, 1963: Doctor Edmond C. Burke of the Mayo Clinic gave a very interesting and informative talk on a medical visit to the U.S.S.R.

April 2, 1963: The Emergency Civil Defense General Hospital Unit, set up at the National Guard Armory in Sioux Falls, was inspected by those attending this meeting.

Respectfully submitted,
E. T. Lietzke, M.D., Councilor
Seventh District

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR EIGHTH DISTRICT

The May meeting was held on May 2, 1962, with Doctor Ed Moore, President, presiding.

Membership was approved for Drs. Rodolfo Bramanti and Carlos Mendoza.

John C. Foster was a guest and discussed the AMA attitude and program of action regarding the administration's Social Security Medical Care pro-

gram. Voted to sponsor advertisements in the local newspaper to place the facts before the general public.

Doctors Steele, Willcockson, and Johnson were nominated for the position of councilor.

The July meeting was held July 15, 1962, and conducted by Dr. Steele, Vice President, in the absence of Doctor Moore.

The Oral Polio Immunization program was approved and the initial program planned for September 1962. Doctors Moore, Marian Auld, Stanage, and Foley are in charge of this program.

An approval of the Blue Shield pilot program for the near-needy was approved.

The October 1962 meeting was held at the State Hospital on October 11, 1962. The meeting was conducted by Doctor Steele.

Reports of the previously conducted Polio Clinics were presented.

Application by Doctor Max Reade was approved.

General chairman of the Annual Meeting to be held in June, 1963, is Doctor J. P. Steele, who conducted the program of a general discussion of the plans and programming. It was discussed in detail and a tentative program and arrangements outlined.

The November 1962 meeting was conducted by Doctor E. J. Moore in Yankton on November 30, 1962.

Doctor Steele presented a report of further progress regarding program and arrangements for the Annual Meeting to be held in June, 1963.

Election of officers was carried out with President being Doctor James P. Steele; Vice President, Doctor R. J. Foley; Secretary, Doctor R. F. Thompson; Treasurer, Doctor Max Reade.

The March meeting was held March 18, 1963, at the Hotel Charles Gurney in Yankton, with Doctor Steele presiding.

John C. Foster was a guest and discussed Annual Meeting requirements.

President Steele discussed plans for the Annual Meeting June 8-11, 1963. Committees which were previously appointed are functioning and progress reports were presented.

Respectfully submitted,
T. H. Sattler, M.D., Councilor
Eighth District

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR NINTH DISTRICT

The elected officers for the year 1962 were as follows:

President—John T. Elston, M.D.
Vice-President—Conrad L. Blunck, M.D.
Secretary-Treasurer—H. H. Theissen, M.D.

The first meeting was held in February. 42 members of the District attended the meeting. In this meeting the recommendation of the Liaison Committee with the Osteopathic Association to the Council of the State Medical Association was considered. Dr. A. A. Lampert discussed the historical background of the Medical Association's concern with the Doctors of Osteopathy and a Committee from the District Medical Society was appointed to study the problem and to make concrete recommendations at the April meeting.

The Assistant Medical Officer in charge of Indian health, Dr. Wherrit, presented a discussion of Indian health problems; however, nothing of significance was accomplished in this discussion.

Drs. Pemberton and Mattox were unanimously approved for nomination to status of honorary members at this meeting.

The professional program was presented by Dr. K. A. Prem, Assistant Professor, OB & Gyn., University of Minnesota, who presented a discussion of current thinking on the "Stein-Leventhal Syndrome."

The April meeting of the Society met at the V.A. Center in Hot Springs. A report of the Special Committee for Study of Relationships Between Medical and Osteopathic Professions was presented by Dr. Geib, the committee consisting of Dr. A. A. Lampert, Chairman, B. S. Clarke, J. N. Hamm, F. R. Williams, R. A. Kovarik, and W. A. Geib. The following resolution was offered to the District Society:

1. That the Black Hills District Medical Society state that it is their belief that it should be considered ethical for physicians to consult professionally with Doctors of Osteopathy who practice medicine on the same scientific basis as M.D.'s.
2. That it is the belief of the Black Hills District Medical Society that Doctors of Osteopathy should be permitted to attend post-graduate medical seminars and to attend local and State Medical Society's scientific sessions if they desire.
3. It is recommended that members of the Black Hills District Medical Society agree that hospitals may have their physician staff membership composed of both Doctors of Medicine and Doctors of Osteopathy; that the decision for joint staffing for an individual hospital should rest with that hospital. If hospitals are not jointly staffed, this does not preclude professional consultation as provided in resolution 1.

Mr. Richard Erickson, Assistant Executive Secretary of the State Association next presented a resolution reaffirming this District's opposition to HR 4222 87th Congress. Such resolution was passed and forwarded to the Congressman of this District.

Mr. Person, Assistant Plans and Training Officer of the State Civil Defense office at Pierre, gave a brief report on mobile hospitals to be made available for Civil Defense training purposes.

The delegates to the annual meeting were instructed to bring before the House of Delegates in June of 1963, a proposal that the annual budget be prepared in advance of the annual meeting so that members of the State Association would have an opportunity to study the budget prior to the annual meeting.

The professional program was presented by C. A. McWhorter, M.D., Professor of Pathology, University of Nebraska who gave a talk concerning "Deaths Occurring Under Unusual Circumstances."

June: The June meeting was moved up to May 22, in order to meet prior to the annual meeting of the State Association. A mail poll taken in the District with regard to resolutions, 1, 2, and 3, concerning relationships with Osteopaths as given above, resulted in the following:

Resolution 1—48 for, 12 against
Resolution 2—44 for, 16 against
Resolution 3—45 for, 17 against

A motion was made that the mail poll be taken to indicate the membership's general feeling in this regard. A second motion for tabling failed of second and the original motion passed with 27 in favor, 4 against, and 4 abstaining. The delegates were then instructed to convey to the House of Delegates the feeling of the Black Hills District Medical Society regarding these resolutions.

A fourth resolution was acted upon favorably and it was unanimously accepted that "The Black Hills District Medical Society immediately formulate plans to institute a hospital medical care evaluation program for all hospitals in the district."

The scientific program was presented by John Murray, M.D., Associate Professor of Medicine,

University of Minnesota, who discussed "Renal Vascular Hypertension."

August: The annual fish-fry was held in Spearfish in August, 109 physicians and guests attending. Dr. Magni Davidson gave a brief report outlining his function as newly elected President of the State Medical Association. He urged physicians to accept their responsibility in the forthcoming senatorial race.

A Committee was appointed for sponsorship by the district of an Oral Polio Vaccination program in this area.

Matthew Block, M.D., Hematologist from the Department of Internal Medicine, University of Colorado, presented a discussion of "Diseases of Too Much and Too Little Iron."

October: The meeting was convened at the Ellsworth AFB Hospital on 9 October, 1962. A demonstration in the Physiological Flight Training Center was given by the Air Force Staff. A nominating committee, consisting of Drs. Kegaries, Kovarik, Leeds and Mead was appointed to report at the December meeting. Discussion developed concerning communications from the Executive Secretary with regard to specific advertising mats to be placed in newspapers during September and October. The Society allocated $200.00 for this project.

December: The final and annual meeting of the Society was held in Rapid City on 13 December. A report by Dr. Whitney on the results of the polio campaign indicated that very good success had been met with in the program.

The nominating committee provided the following slate of candidates which was unanimously accepted:

Officers for 1963
President—Conrad L. Blunck, M.D.
Vice President—Arthur Semones, M.D.
Secretary-Treasurer—Harold L. Frost, M.D.

The scientific presentation was made by Dr. George Knabe, Jr., Professor of Pathology, College of Medicine, U.S.D., in a report of his experiences with Project HOPE in Peru.

During the year there were two deaths, Dr. Thomas Fox of Rapid City and N. T. Mattox, M.D., of Deadwood. New members elected to the Society were Drs. H. L. Frost, Rapid City, L. P. Swisher, Kadoka, Francis P. Kwan, Rapid City, T. P. Roman, of Martin, George Angelos, Hot Springs and R. J. Lynn, Edgemont.

Respectfully submitted,
John T. Elston, M.D., Councilor
Ninth District

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COUNCILOR TWELFTH DISTRICT

The Twelfth District Medical Society held three meetings during the past year. The meetings were held in Webster, Sisseton, and Milbank.

Dr. Warren Jones of Sioux Falls spoke on heart disease at the meeting in Milbank.

Respectfully submitted,
E. A. Johnson, M.D., Councilor
Twelfth District

The Reference Committee recommends the acceptance of this report.

REPORTS OF COMMITTEES AS ADOPTED BY THE HOUSE OF DELEGATES

REPORT OF THE COMMITTEE ON SCIENTIFIC WORK

The Committee on Scientific Work submits the following report of scientific meetings for 1963:

Panel on Diagnosis and Management of Chronic Pulmonary Disease

"The Contribution of the Internist" — Hurst Hatch, M.D.

"The Contribution of the Radiologist" — John Dennis, M.D.

"The Contribution of the Surgeon" — Derward Lepley, Jr., M.D.

"Panel Discussion on Chronic Pulmonary Disease" — Hurst Hatch, M.D.; John Dennis, M.D.; Derward Lepley, Jr., M.D.; Kendall Burns, M.D.

Recent Advances In Medical Practice

"New Aspects of Cervical Cancer" — Ben Peckham, M.D.

"Dizziness" — G. O. Proud, M.D.

"Simplified Fluid Balance Management" — Robert Berry, M.D.

"The Future of Medicine" — C. Eisele, M.D.

"Space Warfare and Radiation" — G. M. McDonnell, M.D.

"Panel on Medicine 10 Years From Now" — G. M. McDonnell, M.D.; Robert Berry, M.D.; Ben Peckham, M.D.; G. O. Proud, M.D.; C. Eisele, M.D.

Peripheral Vascular Disease — Problems of the G. P.

"Symptoms and Medical Treatment" — John A. Spittell, M.D.

"Diagnosis and Surgical Management" — Robert Berry, M.D.

"The How and Why of Peripheral Vascular Disease" — Fred House, M.D.

"Panel Discussion on Peripheral Vascular Disease" — Fred House, M.D.; Robert Berry, M.D.; John Spittell, M.D.; Douglas Cameron, M.D.

The Emergency Room

"Early Surgical Management" — Merle M. Musselman, M.D.

"The Medical Man and the Accident" — Malcom Phelps, M.D.

"Diagnosis of Acute Soft Tissue and Bone Injury by X-Ray" — John Dennis, M.D.

"Panel Discussion on Trauma" — Merle M. Musselman, M.D.; Malcom Phelps, M.D.; John Dennis, M.D.; Robert Berry, M.D.; H. L. Saylor, M.D.

Respectfully submitted,
COMMITTEE ON SCIENTIFIC WORK
C. B. McVay, M.D., Chairman
Merritt Auld, M.D.
L. G. Behan, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON LEGISLATION

This being a legislative year (1963) the Legislative Committee met prior to the beginning of the South Dakota State Legislature. Sessions were held in the fall and again in the winter 1962-1963. All bills associated with the medical profession were discussed and recommendations were made to the House of Delegates. A conference telephone meeting was held during the course of the Legislature and recommendations were sent to the Committee on Public Health and Welfare.

The following bills were discussed:

1. Medical Corporation Amendment
   House Bill 501
2. Kerr Mills Implementation
   House Bill 510
3. Kerr Mills Implementation Funds
   House Bill 622
4. Mental Illness — Board per diem
   House Bill 658
5. Willing Parts of the Body
   House Bill 795
6. Reinstatement of Suspended Licenses
   Senate Bill 150
7. Temporary Licenses
   Senate Bill 302

8. T.V. Control Law
House Bill 942
9. Changes in the Workman's Compensation Law.

Bills that were considered of interest to the Medical Association and had been discussed were Senate Bill 3 requiring seat belts in cars and Senate Bill 26 permitting retail sale of animal drugs.

The Legislative Committee and the Medical Association opposed Abortion Bill -- House Bill 661 which was introduced by Rep. Bielski of Sioux Falls. This Bill was tabled in the House Committee.

The Legislative Committee was extremely pleased with the outcome of the Kerr Mills Implementation Bill. This put South Dakota in a very enviable position, having the first Kerr Mills Implementation Bill of its kind, setting up a pilot program operating on a prepaid insurance basis.

As a representative of the South Dakota State Medical Association's Committee on Legislation I attended a meeting of the AMA Legislative group in Chicago in April of 1963.

The Legislative Committee recommends to the State Medical Association that strong emphasis be placed on the forthcoming problems in regard to federal control of medicine, especially that which is now pending in the Legislature in regard to the care of the aged.

Respectfully submitted,
COMMITTEE ON LEGISLATION
Robert H. Quinn, M.D., Chairman
H. Russell Brown, M.D.
R. F. Hubner, M.D.
T. A. Angelos, M.D.
M. C. Tank, M.D.
T. E. Mead, M.D.

The Reference Committee recommends the acceptance of this report and recommends that individual physicians cooperate in supporting the actions of the Legislative Committee with respect to opposition to the King-Anderson Bill, and participate in the "Operation Hometown" program of the AMA.

REPORT OF THE PUBLICATIONS COMMITTEE

During the past fiscal year, the **South Dakota Journal of Medicine and Pharmacy** published 824 pages, a decrease of 128 pages over the year before.

The advertising showed a decrease of 60⅝ pages, for a total this past year of 460¾ pages.

Respectfully submitted,
PUBLICATIONS COMMITTEE
R. E. Van Demark, M.D., Chairman
G. S. Paulson, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

The committee reports that there were no cases presented to them this year. They are wondering if malpractice is on the decline in our state or if the doctors and attorneys are not utilizing the counsel of this committee.

Respectfully submitted,
COMMITTEE ON MEDICAL DEFENSE
A. P. Reding, M.D., Chairman
G. F. Wood, Jr., M.D.
J. W. Donahoe, M.D.
C. B. McVay, M.D.
C. S. Roberts, Jr., M.D.

The Reference Committee recommends the acceptance of this report, and further recommends that the Committee on Medical Defense and the Medical-Legal Conference Committee be combined and the function of the combined committee then be explained to the members of the Association.

REPORT OF THE COMMITTEE ON MEDICAL SCHOOL AFFAIRS, MEDICAL EDUCATION AND HOSPITALS

The meeting was held at the Medical Association Building in Sioux Falls, on January 12, 1963, and was called to order by Chairman C. B. McVay, M.D.

The minutes of the previous meeting were read and approved.

Dr. Jones moved that the committee recommend to the Council of the State Medical Association that scholarships in the amount of $100.00 each be awarded to a freshman and sophomore student at the South Dakota Medical School; that a scholarship in the amount of $350.00 be awarded to an incoming freshman student; that $100.00 for travel expenses be provided for the delegate to the annual meeting of the Student American Medical Association. The motion was seconded by Dr. Wrage and carried.

Dean Hard announced that the annual dinner dance of the Medical School would be held on March 30, at Cactus Heights Country Club in Sioux Falls.

Dean Hard spoke on the budget appropriation presented at the legislative session this year, and also discussed the proposed retirement plan for faculty at state institutions. He felt that the State of South Dakota was not spending a fair share of the tax dollar collected on higher education. He discussed a chart showing how the South Dakota Medical School rates in comparison with other medical schools in the country in the matter of salaries of faculty members.

Dr. McVay moved that the concern of the Medical Association should be expressed to the Governor and to the Legislature on the lack of money to support Medical education in South Dakota, through the Council. Dr. Wrage seconded the motion and it was carried.

Dean Hard discussed the utilization of AMEF funds at the University of South Dakota Medical School. Dr. Jones moved that a recommendation be made to the Council, suggesting that a letter be drafted to President Weeks of the University stating that AMEF funds are contributed by the doctors of South Dakota to support the University Medical School and that it is within the jurisdiction of the president and dean to utilize the funds to subsidize salaries of the medical school faculty at the school, as necessary. The motion was seconded by Dr. McVay and carried.

Dr. Hard then spoke briefly on the applicants who are applying for entrance to the South Dakota Medical School and the teaching innovations which have been introduced in the past year.

Dr. Hard discussed the Planning Committee which is being established to study the future growth and expansion of the medical school. Dr. Wrage moved that the committee recommend to the Council of the State Medical Association that the president appoint two members to serve on this committee. The motion was seconded by Dr. Jones and carried.

The meeting adjourned at 10:15 p.m.

Respectfully submitted,
COMMITTEE ON MEDICAL SCHOOL AFFAIRS, MEDICAL EDUCATION AND HOSPITALS
C. B. McVay, M.D., Chairman
T. J. Wrage, Jr., M.D.
R. C. Jahraus, M.D.
F. R. Williams, M.D.
Warren Jones, M.D.
E. T. Lietzke, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

The Committee on Medical Economics has not met during the past year. However, in January, 1963, the Council of the Association endorsed a second group loss-of-time insurance program which is now being offered to the membership.

Respectfully submitted,
COMMITTEE ON MEDICAL ECONOMICS
T. H. Sattler, M.D.
C. J. Clark, M.D.

The Reference Committee recommends the acceptance of this report. However, the Committee has noted that the Council has endorsed a second loss of time insurance coverage which the Committee on Medical Economics had not reviewed prior to the Council's endorsement.

REPORT OF THE COMMITTEE ON NECROLOGY

The Committee reports the following deceased physicians in the State during the past year:

T. F. Riggs, M.D., Pierre, passed away in May, 1962.
J. A. Hohf, M.D., Yankton, passed away in July, 1962.
H. O. Ruud, M.D., Rapid City, passed away in July, 1962.
N. E. Mattox, M.D., Deadwood, passed away in November, 1962.
E. E. Gage, M.D., Sioux Falls, passed away in January, 1963.

Respectfully submitted,
COMMITTEE ON NECROLOGY
R. E. Bormes, M.D., Chairman
Margaret Faithe, M.D.
Ole Hvam, M.D.

The Reference Committee recommends the acceptance of this report and respectfully requests of the House of Delegates that the name of the committee be changed to the Committee on Physicians' Obituaries.

REPORT OF THE COMMITTEE ON PUBLIC HEALTH

No assignments were given the Committee on Public Health during 1962. The Chairman has continued to serve on the Governor's Public Health Advisory Committee and, as a result, has a good understanding of the major public health problems throughout South Dakota.

Respectfully submitted,
COMMITTEE ON PUBLIC HEALTH
N. E. Wessman, M.D., Chairman
W. E. Jones, M.D.
Walter Patt, M.D.

The Reference Committee recommends the acceptance of this report and the Reference Committee recommends that a member of the State Public Health Advisory Committee be included in this committee, as is presently the case.

REPORT OF THE COMMITTEE ON CANCER

The following physicians are members of the Executive Board of the South Dakota Division of the American Cancer Society: D. H. Breit, W. A. Geib, G. F. McIntosh, E. G. Huppler, L. C. Askwig, and P. V. McCarthy. All attended the annual meeting of the Society, reviewed its activities and, with others of the board, promoted a program of action for the year of 1963.

The following are accomplishments of the Society in 1962:

Furnished speakers on cancer at the North Dakota-South Dakota state meeting and for the South Dakota Chapter of Internists.

Assisted in a survey of physicians in South Dakota on the use of and facilities for the Papanicolaou smear — conducted by the South Dakota Chapter of Gynecologists.

Supported and sent five graduate teaching nurses to a three weeks course in Oncology, New York University.

Supported the training of two cytotechnicians — one at Mayo Clinic and the other at the University of Nebraska. These courses are for six months. To be accepted one must have a background acceptable to the training schools.

Installed and supported Cancer Registries at:
St. Luke's Hospital, Aberdeen
St. John's McNamara Hospital, Rapid City
Bennett Memorial Hospital, Rapid City
St. Joseph's Hospital, Mitchell
Methodist Hospital, Mitchell
St. Ann's and Memorial Hospitals, Watertown
McKennan Hospital, Sioux Falls

Support to the Tumor Clinic, Sacred Heart Hospital, Yankton.

Conducted workshops showing the latest trends in Cancer Nursing at Sioux Falls, Aberdeen, Rapid City.

Furnished to South Dakota physicians the magazines CA and Cancer Bulletin and other professional publications. There is a supply of educational films on cancer available to qualified parties for group showing.

The Society has organized a Laryngectomy Club, with branches at the University of South Dakota and in Aberdeen. In connection with this it has sponsored training of a speech therapist in Laryngeal voice.

The Society by its charter remits to the National American Cancer Society for its national research program a portion of its funds collected locally.

The Society maintains an office at State Headquarters in Watertown and welcomes inquiry concerning its program.

Respectfully submitted,
COMMITTEE ON CANCER
Paul V. McCarthy, M.D., Chairman
E. H. Collins, M.D.
M. S. Grove, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON TUBERCULOSIS

The Committee on Tuberculosis worked closely during the past year with the South Dakota Tuberculosis and Health Association and the Legislative Research Council in drawing up proposed legislation concerning the care of tubercular patients in South Dakota.

During the legislative session a bill was passed which contained the following provisions:

1. The closing of Sanator.
2. Allowing the State of South Dakota to farm out the chronic cases of tuberculosis to Nebraska, or some other surrounding State, for care.
3. Permitting the Health Department to set up a program of treatment and control and also appropriating money to provide care and treatment of non-chronic individuals close to their home area.

Respectfully submitted,
COMMITTEE ON TUBERCULOSIS
Robert E. Nelson, M.D., Chairman
J. A. Cline, M.D.
Richard Gere, M.D.

The Reference Committee recommends the acceptance of this report and commends the Committee on their long hours in working with the Legislative Research Council.

REPORT OF THE COMMITTEE ON MATERNAL AND CHILD WELFARE

The Committee on Maternal and Child Welfare

held no formal meetings during the past year and has no report to submit.

Respectfully submitted,
COMMITTEE ON MATERNAL AND CHILD WELFARE
F. S. Stahmann, M.D., Chairman
Richard Hosen, M.D.
N. R. Whitney, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE EXECUTIVE COMMITTEE

The Executive Committee met twice during the past year, with all efforts aimed at the proposed MAA program for South Dakota.

The first meeting was held on December 18th in Pierre, at which time the Committee met with the State Welfare Commission to discuss the forthcoming Kerr-Mills bill for South Dakota.

The second meeting of the Committee was held on February 11, 1963, in Pierre. The Executive Committee met jointly with the State Welfare Commission, the Governor, and the State Senate's Health and Welfare Committee. The purpose of this meeting was to negotiate on those problems which had arisen during the legislative session, concerning the MAA (Kerr-Mills) bill which was being considered in the Senate's Health and Welfare Committee.

It should be noted that the MAA Bill passed both the House and Senate and that just recently Blue Cross and Blue Shield have been designated as the insurance carriers for the Kerr-Mills program in South Dakota.

Respectfully submitted,
EXECUTIVE COMMITTEE
Magni Davidson, M.D., Chairman
J. P. Steele, M.D.
A. P. Reding, M.D.
Robert Hayes, M.D.
E. P. Sweet, M.D.
C. J. McDonald, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE GRIEVANCE COMMITTEE

The Grievance Committee has considered two cases during the past year.

Case #1 A patient requested that he be allowed to appear before the Grievance Committee to present additional information on a grievance which had been considered last year. The individual appeared at a special meeting and discussed his case with the members of the committee. Additional information was requested from the attending physician. Inasmuch as nothing further has been heard we can assume that the patient is now satisfied with our handling of the case.

Case #2 This grievance was submitted by a District Medical Society against one of its members concerning his diagnosis and treatment of a disease alleged to be caused by the water supply in a community. The diagnosis had not been confirmed by laboratory tests. The Committee requested that the laboratory personnel of the State Health Department make a complete on-the-site investigation of the situation and that the physician discontinue treatment until a determination could be made. The State Health Department has now made the investigation and we are awaiting the report.

Respectfully submitted,
GRIEVANCE COMMITTEE
A. P. Peeke, M.D., Chairman
A. A. Lampert, M.D.
C. J. McDonald, M.D.
R. A. Buchanan, M.D.
M. M. Morrissey, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON MENTAL HEALTH

The Committee on Mental Health has functioned in terms of several problems this year. Probably the two most important problems being the part that the State will play in setting up a program for Mental Health throughout the State in compliance with the President of the United States' wishes and the dictates and thinking of the National Congress on Mental Health.

The Congress on Mental Health has now met for about nine years and we meet yearly in February, all the chairmen of all fifty states being present plus, this year, the Administrative Assistants and the Executive Secretaries of the State Society in an effort to bring forth a program that will do justice to the inhabitants of our state and the country.

So far as the state is concerned, there will be a state Steering Committee composed of Public Welfare Department and the State Medical Society. We have approximately $50,000 in funds that will be available to us for planning purposes when we submit our plans for the aid to Mental Health in this State. This plan is being put together by Doctor Van Heuvelen of the Public Health Department in Pierre and myself, as Chairman of the Mental Health Committee for the State of South Dakota. I feel that this is making the progress that we would expect. We are going to sift down the problems that exist, trying to take those that are most feasible for a solution and attacking the other ones as time goes on.

It is our feeling that we could amalgamate many of the drives for retarded children and the likes so that we could have an over-all coverage of these patients and probably reduplications of effort in many lines. This is something that will be worked out.

The sub-committee portion of this group will be comprised of representatives from all interested allied groups throughout the State, all allied disciplines, in other words, will be represented on the sub-committee level with an over-all top committee so that things do not get out of control.

Another situation that is being talked about and thought of is a change in the commitment procedure in the State of South Dakota, and thirdly, the reporting and evaluation of people who either attempt or make suicidal gestures. It is felt that more of this goes on than meets the eye and it should be evaluated with an eye to the future.

There has been one question as to medications and the use of same by an out of state physician in the past year which has been evaluated and cared for.

Although the Committee has functioned, probably not as a whole, but by the mails; meetings in the very near future will be forthcoming in order to fully implement our efforts in terms of the Congress on Mental Health.

Respectfully submitted,
COMMITTEE ON MENTAL HEALTH
Richard B. Leander, M.D., Chairman
J. A. Larson, M.D.
L. G. Behan, M.D.
J. C. Hagin, M.D.
A. C. Vogele, M.D.
R. S. Jones, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE BENEVOLENT FUND COMMITTEE

This Fund was started by the Medical Auxiliary at a time when some physicians were in dire distress. Help was provided by the State Association and the Fund was augmented by regular contributions by our Association. Since then, only one physician has needed assistance and after the Fund reached $5,000.00, loans were authorized to

needy medical students. Such loans have necessarily been small.

Some might question the need of this fund, with the plan of $10,000 loans to be made available to medical students. The AMA loans will be bank loans drawing 6% interest, and guaranteed by the AMA. This should be excellent because a young man has the assurance of the ability to complete his education. It is our opinion at the present time that our Benevolent Fund, which is limited to smaller amounts at 4%, might be of need, and your committee recommends the continuance of this Fund.

The money now on hand in this Fund, as well as an itemization of loans is as follows:

Government Bonds	$ 3,000.00
Loans (16)	6,800.00
Cash in Bank	3,068.37
TOTAL ASSETS	$12,868.37

Respectfully submitted,
BENEVOLENT FUND COMMITTEE
W. E. Donahoe, M.D., Chairman
John C. Hagin, M.D.
F. C. Totten, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON RHEUMATIC FEVER AND HEART DISEASE

The Rheumatic Fever Program started in 1958 in cooperation with the South Dakota Heart Association, the State Pharmaceutical Association, the State Department of Health and the State Medical Association.

This Secondary Prevention Program provides Penicillin to medically indigent R.F. patients.

In 1958, 48 patients went on the program
In 1959, 131
In 1960, 95
In 1961, 139
In 1962, 129
In 1963, 26 patients thus far (April 15, 1963)

A total of 568 patients have been registered since the start of the program in 1958. Of these, 121 have discontinued for various reasons, 66 are inactive and 381 are active on the program.

One hundred-one towns and cities are represented on the program. Periodically, the SDHA call attention to the fact that this program is available. Ths is done by sending a form letter to all registered pharmacists and all physicians on the Association's mailing list.

Last fall, the wholesale cost of penicillin was reduced. The President of the Pharmaceutical Association, L. B. Urton, urged all pharmacists in the state to lower the cost of penicillin accordingly to patients on the R.F. Program. Where the cost used to be $5.00 for a three months supply of 100 tablets, it was recommended that the cost be from $2.70 — $3.00 per bottle.

Pharmacists and Physicians have been urged to continue to utilize the necessary forms available from the State Heart Association for patients wishing to participate in the program. This is the only method that the SDHA has for patient control, and the keeping of records of how many patients are benefiting from the program.

Respectfully submitted,
COMMITTEE ON RHEUMATIC FEVER AND HEART DISEASE
John W. Argabrite, M.D., Chairman
H. W. Farrell, M.D.
Marian Auld, M.D.

The Reference Committee recommends the acceptance of this report. The Reference Committee feels that the existence of this assistance may not generally be known and recommends that all the members of the Association take note of it.

SPECIAL COMMITTEES

REPORT OF THE COMMITTEE ON RADIO BROADCASTS AND TELECASTS

The committee on Radio Broadcasts and Telecasts did not meet during the year 1962-63 in that no business was brought to its attention.

Respectfully submitted,
COMMITTEE ON RADIO BROADCASTS AND TELECASTS
W. R. Taylor, M.D., Chairman
P. S. Nelson, M.D.
E. H. Peters, M.D.
R. A. Boyce, M.D.
F. D. Leigh, M.D.
S. B. Simon, M.D.
T. H. Willcockson, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON AMERICAN MEDICAL ASSOCIATION EDUCATION FOUNDATION

1962 again saw us in a letter-solicitation type campaign and $5,698.80 was received.

I notice that the number of contributors in South Dakota is reduced by thirty per cent.

I call these facts to the attention of the delegates and hope that they can see fit to bring these facts to the attention of the local districts and thereby increase the number of contributors lest we find that our schools will have to go to the Federal Government for aid, and thereby be open for still more federal control.

Respectfully submitted,
COMMITTEE ON AMERICAN MEDICAL ASSOCIATION EDUCATION FOUNDATION
S. F. Sherrill, M.D., Chairman
Vernon Cutshall, M.D.
O. J. Mabee, M.D.
H. L. Saylor, M.D.
J. H. DeGeest, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE EDITORIAL COMMITTEE

The Editorial Committee wishes to thank all contributors for their efforts in behalf of the State Journal. Contributions from South Dakota physicians are especially appreciated for the State Journal, and it was recommended that all speakers at these district meetings be contacted by the secretaries of the respective districts for copies of the paper for the State Journal. This past year three papers were received from out-of-state speakers.

A continued effort has been made to improve the typographical errors during the past year; further improvement in this and other areas can be achieved in the future. All suggestions along this line will be gratefully appreciated by the Editorial Committee.

Respectfully submitted,
EDITORIAL COMMITTEE
R. E. Van Demark, M.D., Chairman
B. O. Lindbloom, M.D.
J. A. Anderson, M.D.
W. R. J. Kilpatrick, M.D.
G. E. Tracy, M.D.
H. B. Munson, M.D.
R. F. Thompson, M.D.
Hugo Andre, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON MEDICAL LICENSURE

The State Board of Medical and Osteopathic Examiners met on the regularly appointed times of July 17, 1962 in Rapid City and again on January 16, 1963 in Sioux Falls.

During the course of these regular meetings 19 physicians were licensed by examination and 17 physicians were licensed by reciprocity. One temporary license was changed to a permanent license by board action.

The board of Medical and Osteopathic Examiners authorized two of its members to attend the Federation of State Medical Boards meeting held in association with the Annual Congress on Medical Education sponsored by the American Medical Association. Dr. G. Robert Bartron and Mr. John Foster were in attendance at this meeting.

During the course of regular business a Board recommendation was made and subsequently enacted that the law require a hearing before the Board of Medical Examiners before a license can be reinstated after suspension or revocation. Also, a matter of Board action which was subsequently adopted by the current legislative session was the Board recommendation that that section of the law be repealed concerning emergency medical areas inasmuch as foreign graduates are now screened by the Educational Council for Foreign Medical Graduates.

A progress report was received on a physician currently under scrutiny by the Board and progress was deemed satisfactory. The Board recommended investigation of another physician on charges of unprofessional conduct and this is currently being carried out.

The matter of chiropractic advertising was discussed at some length and the Board recommended that a representative of the Board of Medical and Osteopathic Examiners be in attendance at the next Interprofessional Health Council and that this matter then be brought up to this Executive Body.

The Board of Medical Examiners also met with the Subcommittee on Physical Therapy during the course of its regular business and determined that one member of the subcommittee should personally interview all applicants for licensure and that applicants should also present their credentials to the office of the Board in Sioux Falls.

The Board also discussed the problem of one physician practicing illegally in the state without a proper license and informed the States Attorney of this fact. Following this notification was received that the physician in question left the state.

In addition to the routine business sessions a Special Meeting was held in Pierre on the 14th of August. The specific matter of business for this special meeting was to discuss the complaint filed against one physician for unprofessional conduct. The physician in question was represented by his attorney and as a result of this action the license of the physician in question was suspended for a period of 36 months with the recommendation that the physician be permitted to petition the Board for revocation of that suspension at that time if it was deemed advisable.

A second matter of business involved a complaint charging another physician with unprofessional conduct. The second physician in question was not represented by legal counsel and the Board determined that the hearing be continued indefinitely and that the case be reopened if the physician in question returned to South Dakota to practice medicine. Word has been received subsequently that this physician is deceased and this automatically closes this litigation.

A third matter concerned the license status of a third physician and this physician's license was automatically suspended according to the S. D. Code Suppl. 27.0311 (14). Proper notification was submitted to the physician in question.

Respectfully submitted,

COMMITTEE ON MEDICAL LICENSURE
G. Robert Bartron, M.D., Chairman
J. V. McGreevy, M.D.
R. A. Buchanan, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON VETERANS ADMINISTRATION AND MILITARY AFFAIRS

No report.

Respectfully submitted,
COMMITTEE ON VETERANS ADMINISTRATION AND MILITARY AFFAIRS
R. R. Giebink, M.D., Chairman
C. S. Roberts, M.D.
Loren Amundson, M.D.
T. J. Billion, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON SPAFFORD MEMORIAL FUND

The Dr. Frederick Angler Spafford Memorial Prize is awarded each year to that student who, in the opinion of the committee, has made the most satisfactory progress in the study of Latin, preferably Virgil. This prize was established by the South Dakota State Medical Association and other friends of Dr. Spafford in recognition of his many years of service as a member of the State Board of Regents of Education and especially of his interest in the study of the ancient classics. Amount, $50.00. Awarded to Charles Rick Johnson, Gregory.

Respectfully submitted,
COMMITTEE ON SPAFFORD MEMORIAL FUND
T. E. Eyres, M.D., Chairman

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON PREPAYMENT AND INSURANCE PLANS

The duty of this Committee is to meet and discuss problems referred to it by the State Society or the Blue Shield Plan.

The Blue Shield Plan was able to solve its own problems at its Board of Directors meeting and, therefore, did not need to refer any problems to the Committee. Because there were no problems referred to the Committee, no meeting was necessary. The Committee did not meet during the year 1962-1963.

Respectfully submitted,
COMMITTEE ON PREPAYMENT AND INSURANCE PLANS
Paul Hohm, M.D., Chairman
H. Russell Brown, M.D.
E. A. Johnson, M.D.
J. T. Elston, M.D.
B. F. King, M.D.
D. H. Breit, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON RURAL HEALTH

No Report.

COMMITTEE ON RURAL HEALTH
A. P. Peeke, M.D., Chairman
G. J. Bloemendaal, M.D.
E. F. Kalda, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON NURSES TRAINING

I am reporting as Chairman of the Committee on Nurses Training and have no report to submit as the rural nurses program has been discontinued

and we had no meetings during the course of the year.

However if there is a program set up for nurses training in the medical society among the nursing schools in the state, I believe it would be better if some doctor were appointed from one of the cities where they have a nursing school in operation as he would have closer contact with their problems.

Respectfully submitted,
COMMITTEE ON NURSES TRAINING
J. A. Muggly, M.D., Chairman
C. L. Vogele, M.D.
D. J. Buchanan, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON WORKMEN'S COMPENSATION

No report. There were no meetings of the committee. The same recommendations are still applicable for workmen's compensation.

Respectfully submitted,
COMMITTEE ON WORKMEN'S COMPENSATION
R. R. Giebink, M.D., Chairman
H. J. Bartron, M.D.
J. N. Berbos, M.D.

The Reference Committee has considered the report of the Committee on Workmen's Compensation. The Committee recommends that legislation be introduced at the next session of the legislature providing for the appointment of the Industrial Commissioner for a six year term by the governor, with adequate compensation, in order to secure continuity of the Department and to better formulate changes to improve the Workmen's Compensation Law. The Committee approves the report of this committee with the above recommendation and recommends acceptance of the report.

REPORT OF THE COMMITTEE ON CLINICAL PATHOLOGY

The Clinical Pathology Committee met in Rapid City in December, 1962 to complete the plans for the 1963 workshop for Medical Technologists. The workshop was scheduled for May 16-18, 1963 at Vermillion, S. Dak. The Minneapolis War Memorial Blood Bank will present workshops on "Naturally Occurring Antibodies" and "Immune Antibodies" with Miss Anberg, Mrs. Swanson and Mrs. Arndt as instructors. Dr. Harry W. McFadden of Omaha will present workshops on "Diagnostic Bacteriology." Miss Geneva A. Daland of Boston will present workshops on "Morphology of Red Cells in Anemia," and "Differentiation of Leukomoid Reactions from Leukemia." Mr. C. H. Humes of the Coleman Instrument Company will present workshops on "Spectrophotometry with a Coleman, Jr.". Mr. D. B. Carpenter from Hyland Laboratories will present, "Diagnostic Aids using Latex Fixation Methods." Dr. Willard O. Read of Vermillion will present workshops on EKG and BMR.

About 70 participants are expected for this workshop which has been generously supported by a grant from the South Dakota Medical Association. The Committee has also collected blood slides from about 15 interesting hematologic problems which will be distributed in the near future to Medical Technologists participating in the Standards Program of the Committee.

Respectfully submitted,
COMMITTEE ON CLINICAL PATHOLOGY
Wayne Geib, M.D., Chairman
James L. Vose, M.D.
A. K. Myrabo, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON REHABILITATION

No report.

COMMITTEE ON REHABILITATION
G. W. Smith, M.D., Chairman
R. E. Van Demark, M.D.
Paul Bunker, M.D.
C. F. J. Blunck, M.D.
N. deDianous, Jr., M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON PRESS AND RADIO

To my knowledge there have been no meetings of the Press and Radio Committee, this year.

It has been noted by the Chairman that there has been excellent spot coverage by the AMA on television and some excellent programs on various aspects of medicine on television.

Respectfully submitted,
COMMITTEE ON PRESS AND RADIO
Preston Brogdon, M.D., Chairman
Steve Brzica, M.D.
E. A. Rudolph, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON CARE OF THE INDIGENT

The main activity in the field of medical care for the indigent has been the implementation of the Kerr-Mills Law in South Dakota. Inasmuch as most of this work has been done by the Council, Executive Committee, and Committee on Legislation during the past year, there were no functions carried out by the Committee itself.

Respectfully submitted,
COMMITTEE ON CARE OF THE INDIGENT
H. P. Adams, M.D., Chairman
Clifford F. Binder, M.D.
H. Russell Brown, M.D.
R. E. Greenfield, M.D.
W. O. Hanson, M.D.
E. J. Perry, M.D.
R. F. Hubner, M.D.
C. A. Johnson, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON CIVIL DEFENSE

The "Medical Self-Help" program was implemented during the year with over 700 South Dakotans completing the 16 hour course. Many of those that took part will become instructors for the continued training programs planned for 1963. It is hoped that 15,000 will participate during the coming year. Some schools are requiring it of their high school seniors; nursing classes, church groups and many community organizations have sponsored the course. Physicians throughout the state have been asked to help in an advisory capacity and have done an admirable job.

Hospital disaster planning has begun to be a reality with a somewhat delayed beginning in comparison to the progress made in some states. The disaster plans will be formed at the local level with the aid of a check list developed by the American Medical Association and the American Hospital Association. The "200 Bed Emergency Hospital," which has been supplied by the Department of Civil Defense, has been mobilized in three locations in the state for demonstration purposes.

The swift decline in the interest shown by the public, except for a brief period during the "Cuban Crisis" has been reflected in the inertia demonstrated by the chairman during the past year. It is hoped that in the coming year the chairman can

stimulate more enthusiasm in the activities of the committee.

Respectfully submitted,
COMMITTEE ON CIVIL DEFENSE
Courtney W. Anderson, M.D., Chairman
Harry Brauer, M.D.
Lothar Kaul, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE FOR IMPROVEMENT OF PATIENT CARE

Since our last report this group of our Association has had two meetings with the South Dakota Joint Commission for the Improvement of Patient Care. The first meeting was held September 5, 1962 in Huron. The program consisted of a panel discussion by D. J. Buchanan, M.D. of Huron; Inez Hinsvark of Brookings; and Sister M. Richard. They discussed the topic, "Improvement of Bedside Nursing."

Two recommendations were made to be sent back to the sponsoring organizations:

1. That the functions, standards and qualifications of R.N.'s, LPN's be made available to doctors, administrators and nurses.
2. That this committee request directions from the sponsors in implementing some type of educational program for all levels of nurses.

The second meeting of the group was held again in Huron on March 27, 1963. Again a panel discussion was held and this topic dealt with the "Nurse Anesthetist in our S. D. Hospitals." The panel consisted of a lawyer, two nurse anesthetists and a physician. They discussed the qualifications and position of the anesthetists as well as their position in medical legal complications.

Respectfully submitted,
COMMITTEE FOR IMPROVEMENT OF PATIENT CARE
D. J. Buchanan, M.D., Chairman
V. R. Vonburg, M.D.
M. E. Sanders, M.D.
J. A. Muggly, M.D.
C. L. Vogele, M.D.
Howard Wold, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON SCHOOL HEALTH

The State Committee on School Health submits the following report:

Although no meetings were held, correspondence is being carried out concerning the possibility of developing a uniform pre-college admittance physical form.

We hope to be able to present such a form for your approval by next year, or even for Council approval prior to the spring session. We hope that the Districts have not only appointed School Health Committees, as per last year's resolution, but that the information on policy from the State level has proven to be of use to them.

Respectfully submitted,
COMMITTEE ON SCHOOL HEALTH
Warren Anderson, M.D., Chairman
G. E. Tracy, M.D.
T. E. Eyres, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON BUDGET AND AUDIT

The committee met in Sioux Falls Sunday morning January 13, 1963 to consider the proposed budget for the 1963-1964 fiscal year. This budget was read and accepted by the Council at the meeting that afternoon. The proposed budget was printed in the February 1963 issue of the SOUTH DAKOTA JOURNAL OF MEDICINE AND PHARMACY and will also be in the Delegates' Handbook to be presented to the House of Delegates at the annual meeting for approval.

The audit will be prepared by a Certified Public Accountant and presented to the House of Delegates at the same time.

Respectfully submitted,
COMMITTEE ON BUDGET AND AUDIT
A. P. Reding, M.D., Chairman
A. K. Myrabo, M.D.
R. F. Hubner, M.D.

SOUTH DAKOTA STATE MEDICAL ASSOCIATION

INCOME

State Dues	$40,000.00
Annual Meeting	6,300.00
Interest	200.00
Miscellaneous	1,045.00
Salary Reimbursement	100.00
Car Reimbursement	690.00
	$48,835.00

EXPENSES

Salary, Executive Secretary	$ 7,500.00
Salary, Other	7,300.00
Social Security	420.00
Legal & Audit	700.00
Telephone & Telegraph	1,500.00
Office Supplies & Equipment	2,725.00
Dues & Subscriptions	1,200.00
Officers Travel	2,200.00
Annual Meeting	5,000.00
Public Relations	4,000.00
Rent	2,400.00
Unemployment Taxes	40.00
Postage	1,600.00
Legislative Expense	1,850.00
Benevolent Fund	400.00
Medical School Endowment	200.00
Ladies Auxiliary	1,000.00
Refunds	200.00
Car Expenses	860.00
Staff Travel	4,500.00
Clinical Pathology	1,000.00
Miscellaneous	500.00
Reserve	1,000.00
Balance to Surplus	740.00
	$48,835.00

JOURNAL—INCOME

Advertising	$24,000.00
Subscriptions	1,200.00
Miscellaneous	750.00
Refunds	100.00
	$26,050.00

JOURNAL—EXPENSES

Salary, Business Manager	$ 3,600.00
Salary, Editors	1,440.00
Legal & Audit	50.00
Rent	900.00
Telephone & Telegraph	175.00
Office Supplies	17,842.00
Taxes	30.00
Unemployment Taxes	—
Postage	250.00
Travel Expense	350.00
Balance to Surplus	13.00
Due Midwest-Beach from 62-63	1,400.00
	$26,050.00

GROUP LIFE INSURANCE INCOME

Premiums	$30,000.00

EXPENSES

Payments to Insurance Company	$29,100.00
Postage	50.00

Legal & Audit	50.00
Supplies	50.00
Balance to Surplus	750.00
	$30,000.00

BUILDING FUND INCOME

Blue Shield Rent	$ 4,800.00
Association Rent	2,400.00
Journal Rent	900.00
Board of Examiners Rent	300.00
Nurses Association Rent	900.00
OAA Rent	2,250.00
	$11,550.00

EXPENSES

Janitor & Repair	$ 1,400.00
Utilities	1,600.00
Interest	2,600.00
Repayment of Loans	2,450.00
Taxes & Insurance	2,000.00
Legal & Audit	1,500.00
	$11,550.00

The Reference Committee recommends the acceptance of the budget as approved by the Council, without change.

REPORT OF THE COMMITTEE ON AGING

The Committee on Aging held no meetings during the year, due to the fact that much of the activity of the Committee was performed by the executive office and the Executive Committee. The Committee on Aging wishes to commend the Executive Committee for its successful implementation of the Kerr-Mills legislation in South Dakota. We would also like to report that the executive secretary, Mr. Foster, represented the State of South Dakota on behalf of the Governor at the Conference on Aging sponsored by the Department of Health, Education and Welfare in Washington, D. C.

Respectfully submitted,
COMMITTEE ON AGING
Warren Jones, M.D., Chairman
C. F. Johnson, M.D.
H. R. Wold, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON CORONER'S LAW

It would be desirable to present a bill to the 1964 session of the Legislature to modify and improve the present Coroner's Law. All of the pathologists in the State have been sent copies of a proposed Coroner's Law and a discussion of the proposed law. The Pathologists have been asked to contact the various legislators in their area and to prepare discussion for presentation to interested groups.

To date progress for enacting a new Coroner's Law in South Dakota has been slow and it is hoped that greater emphasis can be placed upon this proposed legislation during the remainder of 1963.

Respectfully submitted,
COMMITTEE ON CORONER'S LAW
W. A. Geib, M.D., Chairman
R. C. Jahraus, M.D.
R. H. Hayes, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE COMMITTEE ON TRAFFIC SAFETY

The Committee on Traffic Safety held no meetings during the past year. The chairman corresponded with Governor Gubbrud on the seat belt legislation during the legislative session and also reported information on the outcome of the law to Dr. Kennedy, who is field chairman for the Committee on Trauma of the American College of Surgeons. The chairman of the committee has requested, as state chairman of the South Dakota Chapter of the American College of Surgeons, that the seat belt law be considered on the agenda for the next legislative session. One member of the Committee, Dr. J. J. Stransky, attended the meetings of the Governor's Committee on Traffic Safety.

Respectfully submitted,
COMMITTEE ON TRAFFIC SAFETY
H. L. Saylor, Jr., M.D., Chairman
J. J. Stransky, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE MEDICAL-LEGAL CONFERENCE COMMITTEE

A Medical Legal Conference was held in Sioux Falls, on September 15, 1962. Appearing on the program were David W. Louisell, Professor of Law at the University of California Law School at Berkeley; Richard P. Bergen and Arnold Streich of the AMA's Law Department; Don Bierle, Yankton; James Adams, Sioux Falls; L. G. Behan, M.D., Yankton; Richard P. Crowder, M.D., Rapid City; R. A. Standard, M.D., Aberdeen; Kendall Burns, M.D., Sioux Falls; E. S. Palmerton, M.D., Rapid City; C. L. Swanson, M.D., Pierre; Don Porter, Pierre; Keith Newcomb, Sioux Falls; and H. T. Fuller, Mitchell. Approximately 100 persons attended the conference.

The Chairman of the Committee attended the National Medical Legal Symposium in Miami Beach, Florida, in March. This program was very enlightening and was attended by over 1,000 doctors and lawyers.

The Committee has been studying plans for implementing a program of handling malpractice cases reported in the State by the establishment of a Joint Screening Panel composed of an equal number of doctors and lawyers. Information from several states has been obtained and is under study at the present time.

The Committee has tentatively set the date of September 12, 1964 for the next Medical Legal Conference in South Dakota. The meeting will be held in Pierre, S. D.

Respectfully submitted,
COMMITTEE ON MEDICAL LEGAL CONFERENCE
C. L. Swanson, M.D., Chairman
Ted Hohm, M.D.
D. L. Ensberg, M.D.

The Reference Committee recommends the acceptance of this report.

REPORT OF THE LIAISON COMMITTEE WITH THE S. D. PHARMACEUTICAL ASSOCIATION

The Committee held no meeting during the year, and all business was handled per telephone.

In keeping with recommendations made in past years no problems or problem areas have appeared between the two organizations, and no written requests for consideration by the Joint Committee have been received by the executives of either organization.

One interesting sidelight occurred during the legislative session at which time a bill was introduced which was considered to be of interest to the Pharmaceutical Association in which physicians appeared before the legislative committee to testify that the wanton sale of drugs would be injurious to the public health. This decision was

made to do so on the spur of the moment and it was felt to be acceptable to both Associations.

The Committee feels that the action of the Rapid City Pharmaceutical Society to establish an emergency drug depot is to be commended, and perhaps this type of program can be presented in the future to assist physicians in obtaining less common medication when needed. Certainly, botulism antitoxin and cholera vaccine would be difficult for all to obtain unless such a drug depot would have the stock.

It is contemplated that the forthcoming legislative year will necessitate several meetings of this Committee.

Respectfully submitted,
LIAISON COMMITTEE WITH THE S. D. PHARMACEUTICAL ASSOCIATION
Robert H. Hayes, M.D., Chairman
V. V. Volin, M.D.
Dagfin Lie, M.D.

The Reference Committee recommends the acceptance of this report.

DISTINGUISHED SERVICE AWARDS

Started in 1951

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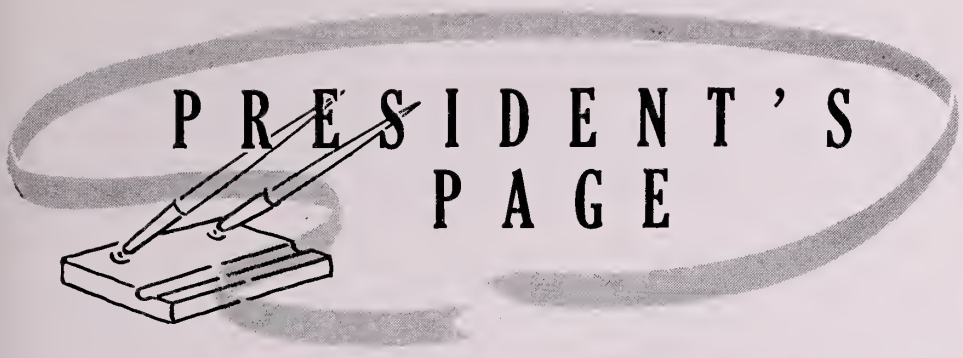
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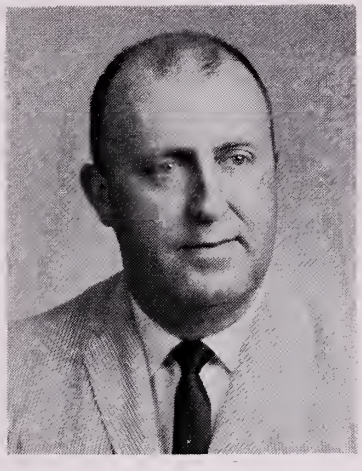
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Allen, S. W. ..... Watertown
Alway, J. D. ..... Aberdeen
Amundson, Loren ..... Webster
Anderson, A. B. ..... Lead
Anderson, C. Wm. ..... Sioux Falls
Anderson, J. A. ..... Madison
Anderson, T. R. ..... Sioux Falls
Anderson, W. R. ..... Sioux Falls
Andre, H. C. ..... Vermillion
Angelos, G. ..... Hot Springs
Angelos, T. ..... Canton
Arbon, R. K. ..... Lake Preston
Argabrite, J. W. ..... Watertown
Arneson, W. A. ..... Sioux Falls
Askwig, L. C. ..... Pierre
Aspaas, P. K. ..... Dell Rapids
Auld, Marian ..... Yankton
Auld, M. A. ..... Yankton
Auskaps, R. ..... Watertown
Avots-Avotins, K. ..... Texas
Avotins, R. ..... Faulkton
Bailey, J. D. ..... Rapid City
Baker, C. ..... Yankton
Bankead, J. H. ..... Sioux Falls
Bareis, R. J. ..... Rapid City
Barnett, G. L. ..... Sioux Falls
Bartron, G. R. ..... Watertown
Bartron, H. J., Jr. ..... Watertown
Batt, E. J. ..... Sisseton
Becker, S. F. ..... Sioux Falls
Begley, B. J. ..... Sioux Falls
Behan, L. G. ..... Yankton
Behrens, C. L. ..... Rapid City
Belatti, R. G. ..... Madison
Bell, G. Robert ..... De Smet
Benjamin, M. B. ..... Michigan
Berbos, J. N. ..... Aberdeen
Berg, S. ..... Tyndall
Berry, J. T. ..... Mitchell
Berry, J. T. (M.S.)
Berzins, R. ..... Bowdle
Billion, T. J., Jr. ..... Sioux Falls
Binder, C. F. ..... Chamberlain
Bloemendaal, G. J. ..... Ipswich
Blunck, C. F. ..... Rapid City
Bobeck, C. J. ..... Rapid City
Borgmeyer, H. J. ..... Rapid City
Bormes, R. E. ..... Aberdeen
Boyce, R. A. ..... Rapid City
Brakss, V. ..... Watertown
Brauer, H. H. ..... Sisseton
Bray, R. B. ..... Rapid City
Breit, D. H. ..... Sioux Falls
Brewster, C. B. ..... Watertown
Brinkman, W. C. ..... Sisseton
Brzica, S. M. ..... Sioux Falls
Brogdon, P. P. ..... Mitchell
Brown, H. R. ..... Watertown
Buchanan, D. ..... Huron
Buchanan, R. A. ..... Huron
Bunker, P. G. ..... Aberdeen
Burleigh, J. ..... Sioux Falls
Burns, E. A. ..... Sioux Falls
Burns, K. R. ..... Sioux Falls
Butler, J. M. ..... Hot Springs
*Byrne, J. R. ..... Edgemont
Calene, J. L. ..... Aberdeen
Cameron, D. E. ..... Rapid City
*Carney, M. ..... Manhattan, Kan.
Carson, L. E. ..... Lead
Chalmers, J. H. ..... Sioux Falls
Charbonneau, Y. H. ..... Huron
*Chassell, J. L. ..... Belle Fourche
Chu, C. L. ..... Illinois
Church, Bill G. ..... Sioux Falls
Clark, B. S. ..... Spearfish
Clark, C. A. ..... Lead
Clark, C. J. ..... Watertown
Cline, D. W. ..... Yankton
Cline, J. A. ..... Rapid City
Collins, E. H. ..... Gettysburg
Cook, W. S. (M.S.)
Coram, F. J. (M.S.)
Cosand, Marion ..... Winner
Cottam, G. I. W. ..... Sioux Falls
Cowan, J. T. ..... Pierre
Cowan, L. K. ..... Rapid City
*Crane, H. L. Washington, D. C.
Crowder, R. B. ..... Rapid City
Currie, K. P. ..... Britton
Cutshall, V. H. ..... Sioux Falls
Cutshall, V. K. ..... Sioux Falls
Czajkowskyj, Ruth ..... Veblen
Czajkowskyj, T. ..... Veblen
D'Arata, E. J. ..... New Underwood
Damm, W. P. ..... Redfield
Davidson, H. E. ..... Sioux Falls
Davidson, M. ..... Brookings
Dean, Roscoe ..... Wess. Springs
de Almeida, M. J. ..... Viborg
de Boer, A. ..... Lennox
deDianous, N., Jr. ..... Aberdeen
De Geest, J. H. ..... Miller
Delaney, R. J. ..... Mitchell
Delaney, W. A., Jr. ..... Mitchell
Devick, J. S. ..... Colton
Donahoe, J. W. ..... Sioux Falls
Donahoe, R. R. ..... Sioux Falls
*Donahoe, S. A. ..... Sioux Falls
*Donahoe, W. E. ..... Sioux Falls
Drissen, E. M. ..... Britton
Driver, D. R. ..... Sioux Falls
Driver, I. E. ..... Aberdeen
Duimstra, F. ..... Sioux Falls
Dulaney, C. H. ..... Ft. Meade
Dzintars, P. F. ..... Faith
Eckrich, J. A. ..... Aberdeen
Eirinberg, I. ..... Sioux Falls
Elston, J. T. ..... Rapid City
Ensburg, D. L. ..... Sioux Falls
Epp, D. L. ..... Freeman
Erickson, E. G. ..... Sioux Falls
Erickson, O. P. ..... Valley Springs
Eyres, T. E. ..... Vermillion
Fahrenwald, M. ..... Redfield
Fairbanks, W. H. ..... Vermillion
Faithe, Margaret ..... Wakonda
Farrell, H. W. ..... Sioux Falls
Fedt, Donald ..... Watertown
Feehan, J. J. ..... Rapid City
Ferrell, M. R. ..... Sioux Falls
Finley, R. C. ..... Rapid City
Fisk, R. G. ..... Dell Rapids
*Fleeger, R. B. ..... Lead
Foley, R. J. ..... Tyndall
Fox, S. W. ..... Pierre
Freimark, L. ..... Rapid City
Friefeld, S. ..... Brookings
Fritz, W. H. ..... Mitchell
Frost, D. M. ..... Sioux Falls
Frost, H. L. ..... Rapid City
Geib, W. A. ..... Rapid City
Gerber, B. C. ..... Aberdeen
Gere, R. G. ..... Mitchell
Giebink, R. R. ..... Sioux Falls
Gilbert, F. J. ..... Belle Fourche
Gillis, F. D. ..... Mitchell
Glood, D. ..... Viborg
Graff, L. W. ..... Britton
Grau, H. J. ..... Rapid City
*Green, R. D. ..... Sioux Falls
Greenfield, D. L. ..... Sioux Falls
Greenfield, R. E. ..... Sioux Falls
Greenough, E. E. ..... Sioux Falls
Gregg, J. B. ..... Sioux Falls
Gregory, D. A. ..... Milbank
Grove, M. S. ..... Sioux Falls
Grover, W. W. ..... Bondeul, Wisc.
Gryte, C. F. ..... Huron
Gunter, J. E. ..... Rapid City
Guzman, L. G. (M.S.) ..... Rosebud
Gwinn, C. B. ..... Rapid City
Haas, F. W. ..... Yankton
Hagan, A. S. ..... Faulkton
Hage, W. J. ..... Sioux Falls
Hagin, J. C. ..... Miller
Hamm, J. N. ..... Sturgis
Hanisch, E. C., Jr. ..... Huron
Hansen, H. F. ..... Sioux Falls
Hanson, W. O. ..... De Smet
Hare, H. J. ..... Rapid City
Hare, Lyle ..... Spearfish
Hayes, R. H. ..... Winner
Heinrichs, E. H. ..... Watertown
Heinzen, F. J. (M.S.)
Henry, Robert ..... Brookings
Hewitt, J. M. ..... Rapid City
*Hill, J. F. ..... Yankton
Hockett, R. D. ..... Mitchell
Hofer, E. A. ..... Huron
Hohm, Paul ..... Huron
Hohm, Theo. ..... Huron
Holland, L. W. ..... Chamberlain
Holleman, W. W. ..... Rapid City
Honke, R. W. ..... Wagner
Hornbeck, N. B. (M.S.)
Horthy, A. ..... Kennebec
Horthy, K. ..... Kennebec
Hosen, R. S. ..... Sioux Falls
Hoskins, J. H. ..... Sioux Falls
Hubner, R. F. ..... Yankton
Huet, G. M. ..... Huron
Huppler, E. G. ..... Watertown
Hura, R. ..... Howard
Ihle, C. W. ..... Sioux Falls
Illig, K. M. ..... Pierre
*Jackson, A. S. ..... Rapid City
Jacobson, T. R. ..... Hot Springs
Jameson, G. M. ..... Sioux Falls
Jahraus, R. C. ..... Pierre
Janavs, V. ..... Milbank
Janis, J. B. ..... Sioux Falls
Janss, W. B. ..... Rapid City
Jatoi, A. M. ..... Deadwood
Johnson, C. A. ..... Lemmon
Johnson, C. F. ..... Yankton
Johnson, E. A. ..... Milbank
Jones, R. S. ..... Rapid City
Jones, W. E. ..... Sturgis
Jones, W. L. ..... Sioux Falls
Judge, W. T. ..... Milbank
Kalda, E. F. ..... Platte
Karlins, W. H. ..... Webster
Kass, Joseph ..... Rosholt
Kaufman, I. I. ..... Freeman
Kaul, Lothar ..... Sioux Falls
Keegan, Agnes ..... Aberdeen
Kegaries, D. L. ..... Rapid City
Keller, L. W. ..... Webster
*Keller, S. A. ..... California
Kelly, W. T. (M.S.)
Kemper, C. E. ..... Viborg
Kershner, C. M. ..... Brookings
Kilpatrick, W. R. J. ..... Huron

King, B. F. ..... Aberdeen
King, E. A. ..... Rapid City
King, L., Jr. ..... Sioux Falls
Kittelson, H. O. ..... Sioux Falls
Klar, W. ..... Flandreau
Kleinsasser, G. ..... Scotland
Knabe, G. W. ..... Vermillion
Knowles, R. C. ..... Sioux Falls
Kohlmeyer, F. C. ..... Sioux Falls
Kooiker, R. H. ..... Illinois
Koren, P. H. ..... Rapid City
Kovarik, R. A. ..... Rapid City
Kramer, R. K. ..... Yankton
Kryger, P. ..... Corsica
Kucera, W. ..... Lead
Kwan, F. P. ..... Rapid City
Lakstigala, Peter ..... White River
Lampert, A. A. ..... Rapid City
Larson, C. S. ..... Sioux Falls
Leander, R. B. ..... Sioux Falls
Leeds, J. F. ..... Hot Springs
Leigh, F. D. ..... Huron
Lenz, B. T. ..... Huron
Lenz, B. W. (M.S.) ..... Rosebud
Leon, Paul ..... Aberdeen
Leraan, L. G. ..... Sioux Falls
Lewis, H. R. ..... Mitchell
Lewis, J. R. (M.S.)
Lie, Dagfinn ..... Webster
Lietzke, E. T. ..... Beresford
Lindbloom, B. O. ..... Pierre
Lindholm, D. D. (M.S.)
Lloyd, J. H. ..... Mitchell
Lloyd, J. H., Jr. ..... Mitchell
Lovering, J. ..... Webster
Lowe, H. E. ..... Mobridge
Lowe, J. A. ..... Mobridge
Lushbough, B. C. ..... Brookings
Lydiatt, J. ..... Hot Springs
Lynn, R. J. ..... Edgemont
Lysloff, G. O. ..... Rapid City
Lyso, M. ..... Yankton
Mabee, D. R. ..... Mitchell
Mabee, J. O. ..... Mitchell
Mabee, O. J. ..... Mitchell
MacDonald, R. G. ..... Lemmon
Mangulis, G. ..... Philip
Manning, D. H. ..... Sioux Falls
Maresh, E. R. ..... Sioux Falls
Marousek, M. ..... Belle Fourche
Marr, L. ..... Estelline
Marr, V. ..... Estelline
Mattice, Lloyd ..... Sioux Falls
Mattox, J. ..... Deadwood
Maxwell, R. T. ..... Clear Lake
Mead, T. ..... Spearfish
Merryman, M. P. ..... Rapid City
Meyer, W. L. ..... Hot Springs
Michael, A. ..... Pakistan
Millea, R. P. ..... Rapid City
*Mills, G. W. ..... Wall
Moller, C. ..... Dell Rapids
Mongeon, C. L. ..... California
Monson, C. D. ..... Parkston
Moore, E. J. ..... Vermillion
Morrissey, M. M. ..... Pierre
Mueller, E. H. ..... Tripp
Muggly, J. A. ..... Madison
Munson, H. B. ..... Rapid City
Murdy, B. C. ..... Aberdeen
Murdy, C. B. ..... Aberdeen
Murphy, J. C. ..... Murdo
Mutch, M. G. ..... Sioux Falls
Myrabo, A. K. ..... Sioux Falls
McCann, J. P. ..... Parkston
McCarthy, P. V. ..... Aberdeen
McCroskey, R. C. ..... Rapid City
McDonald, C. J. ..... Sioux Falls
McGreevy, E. J. ..... Sioux Falls
McGreevy, J. V. ..... Sioux Falls
McHardy, B. R. ..... Sioux Falls
McIntosh, G. F. ..... Eureka
M.S.—Indicates Military Service

McManus, T. B. ..... Wess. Springs
McVay, C. B. ..... Yankton
*Nelson, J. A. ..... California
Nelson, M. H. (M.S.)
Nelson, P. S. ..... Watertown
Nelson, R. E. ..... Sioux Falls
Nemer, R. G. ..... Gregory
Nieher, W. C. (M.S.)
Nolan, B. P. ..... Mobridge
Nordmo, S. H. ..... Vermillion
Norgello, V. ..... Redfield
Nozik, H. I. (M.S.)
Ogborn, R. J. ..... Sioux Falls
Olson, R. G. ..... Sioux Falls
Opheim, W. L. ..... Sioux Falls
Orr, R. T. ..... Sioux Falls
Otey, B. T. ..... Flandreau
O'Toole, T. F. ..... Rapid City
Owen, G. S. ..... Rapid City
Palmerton, E. S. ..... Rapid City
Pangburn, M. W. ..... Miller
*Pankow, L. J. ..... Sioux Falls
*Parke, L. L. ..... Canton
Pasek, E. A. ..... Sioux Falls
Patt, W. H. ..... Brookings
Patterson, D. ..... Redfield
Paulson, G. S. ..... Rapid City
Peeke, A. P. ..... Volga
Peabody, P. D., Jr. ..... Sisseton
Peik, D. J. ..... Sioux Falls
Peiper, W. ..... Mitchell
*Pemberton, M. O. ..... Rapid City
Perry, E. J. ..... Redfield
Peters, E. H. ..... Sioux Falls
Petres, A. ..... Salem
Pfisterer, T. R. ..... Redfield
Plowman, E. T. ..... Brookings
Pokorny, J. F. ..... Newell
Porter, M. H. ..... Parkston
Price, Ronald ..... Armour
Quinn, R. H. ..... Sioux Falls
*Quinn, R. J. ..... Sioux Falls
*Radusch, F. J. ..... Rapid City
Ranney, Brooks ..... Yankton
Reade, D. M. ..... Yankton
Reagan, J. L. ..... Madison
Reagan, P. R. ..... Sioux Falls
Reaney, D. B. ..... Yankton
Reding, A. P. ..... Yankton
Reul, T. W. ..... Watertown
Riesberg, E. ..... Yankton
Roberts, C. S., Jr. ..... Brookings
Rodine, J. C. ..... Aberdeen
Roesel, R. W. ..... Chicago
Roman, T. P. ..... Martin
Roper, C. E. ..... Hot Springs
Rousseau, M. C. ..... Watertown
Rudolph, E. A. ..... Aberdeen
Ryan, C. F. ..... Watertown
Sabbagh, M. ..... Lemmon
Salladay, I. R. ..... Ft. Meade
Sanders, M. E. ..... Redfield
Sanderson, E. W. ..... Sioux Falls
Sattler, T. H. ..... Yankton
Saxton, A. J. ..... Rapid City
Saxton, W. H. ..... Huron
Saylor, H. L., Jr. ..... Huron
Schabauer, E. A. ..... Hoven
Shaeffer, J. H. ..... Sioux Falls
Scheffel, A. ..... Redfield
Scheller, D. L. ..... Arlington
Sebring, F. U. ..... Vermillion
Semones, A., Jr. ..... Lead
Sercl, W. F. ..... Sioux Falls
Sherrill, S. F. ..... Belle Fourche
Shreves, H. ..... Sioux Falls
Simon, S. ..... Pierre
Skogmo, B. R. ..... Mitchell
Slingsby, J. B. ..... Rapid City
Smiley, J. C. ..... Deadwood
Smith, G. W. ..... Sioux Falls
Spain, M. L. ..... Rapid City

Spears, B. ..... Pierre
Spicer, E. R. P. ..... Aberdeen
Spiry, A. W. ..... Mobridge
Staats, R. S. (M.S.) ..... New York
Stahmann, F. S. ..... Sioux Falls
Stanage, W. F. ..... Yankton
Standard, R. A. ..... Aberdeen
Steele, G. H. ..... Aberdeen
Steele, J. P. ..... Yankton
Steiner, P. ..... Sioux Falls
Stensrud, H. J. ..... Madison
Stern, C. A. ..... Sioux Falls
Stiehl, R. L. ..... Burke
Stoltz, C. R. ..... Watertown
Stone, D. Q. (M.S.)
Stransky, J. J. ..... Watertown
Strauss, B. ..... Parker
Studenberg, D. ..... Gregory
Studenberg, J. E. ..... Winner
Sullivan, W. S. (M.S.)
Sundet, N. J. ..... Kadoka
Swanson, C. L. ..... Pierre
Sweeny, W. T. ..... Aberdeen
Sweet, E. P. ..... Burke
Swisher, L. P. ..... Kadoka
Tank, M. C. ..... Brookings
Taylor, Wm. R. ..... Aberdeen
Tesar, C. E. ..... Rapid City
Theissen, H. H. ..... Rapid City
Thompson, R. F. ..... Yankton
Tidd, J. T. ..... Yankton
Tieszen, A. J. ..... Pierre
Tobin, F. J. ..... Mitchell
Tobin, L. W. ..... Mitchell
Torkildson, G. ..... McLaughlin
Totten, F. C. ..... Lemmon
Tracy, G. E. ..... Watertown
Tschetter, P. S. ..... Huron
Turner, C. R. ..... Brookings
Urbanyi, E. W. ..... Gettysburg
*Van Demark, G. E. ..... Sioux Falls
Van Demark, R. E. ..... Sioux Falls
Van Heuvelen, G. J. ..... Pierre
Van Lier, P. C. ..... Sioux Falls
Villa, J. P. ..... Freeman
Vogele, A. C. ..... Aberdeen
Vogele, C. L. ..... Aberdeen
*Volin, H. P. ..... Lennox
Volin, V. V. ..... Sioux Falls
Vonburg, V. R. ..... Mitchell
Vose, J. L. ..... Mitchell
Votaw, F. ..... Sioux Falls
Wall, D. W. (M.S.)
Watson, E. S. ..... Brookings
Weatherill, D. W. ..... Mitchell
Weaver, R. J. ..... Sioux Falls
Weber, R. A. ..... Mitchell
Wegner, K. H. ..... Sioux Falls
Werthmann, H. ..... Pierre
Wessman, N. E. ..... Sioux Falls
Westaby, J. R. ..... Madison
Westaby, R. S., Jr. ..... Rapid City
Westland, G. I. ..... Onida
White, F. T. (M.S.)
Whitney, N. R. ..... Rapid City
Whitson, G. E. ..... Madison
Willcockson, T. H. ..... Yankton
Willen, Abner ..... Clark
Williams, F. R. ..... Rapid City
Williams, M. F. ..... Sioux Falls
Wingert, Marvin ..... Garretson
Winters, M. D. (M.S.)
Wold, H. R. ..... Madison
Wood, G. F. ..... Rapid City
Wrage, T. R., Jr. ..... Watertown
Wright, J. C. (M.S.)
Yackley, J. V. ..... Rapid City
Zakahi, R. J. ..... Pierre
Zandersons, V. ..... Woonsocket
*Zimmerman, Goldie E.
Missoula, Montana
Zvejnieks, K. ..... Leola
*—Indicates Honorary Membership





Greetings, Fellow Members:

I trust that you are among those who attended the annual State meeting at Yankton this year, and yet I realize, through necessity, many stayed at home and "minded the store," and therefore, at least one half of you did not attend. I think that those who were present will agree with me that this year's meeting was outstanding. I am sure the Association owes a vote of thanks to the Eighth District. Their enthusiasm and apparent unlimited energy, was largely responsible for a well received annual meeting both from a standpoint of a scientific and nonscientific session. I am sure that the Auxiliary enjoyed the program arranged for them as much as we did the one arranged for us.

Some of the speakers and some of the panels of speakers presented some particularly ticklish questions. Certainly, Dr. McDonnel from U.C.L.A., in his discussion of six million volt chest x-rays, opened our eyes to what we might expect in the future. I am sure that twenty years ago my writing that one of the speakers' proposed use of molds to treat infection would have raised just as many eyebrows.

Emphasis upon chronic pulmonary disease was particularly appropriate, since we all face this and deal with it. Of particular interest was the conclusion of one of the panels, that a simple test of pulmonary function as could be accomplished by a physician in his office would be adequate for written appraisal of disability that we are all called upon to make many times. This should go a long way in reducing the amount of paper work which, as Dr. Robert E. Van Demark pointed out in the June issue of our Journal, is reducing the medical service given to the public by us. Indeed, he hit upon a crucial note in the shortage of Doctors.

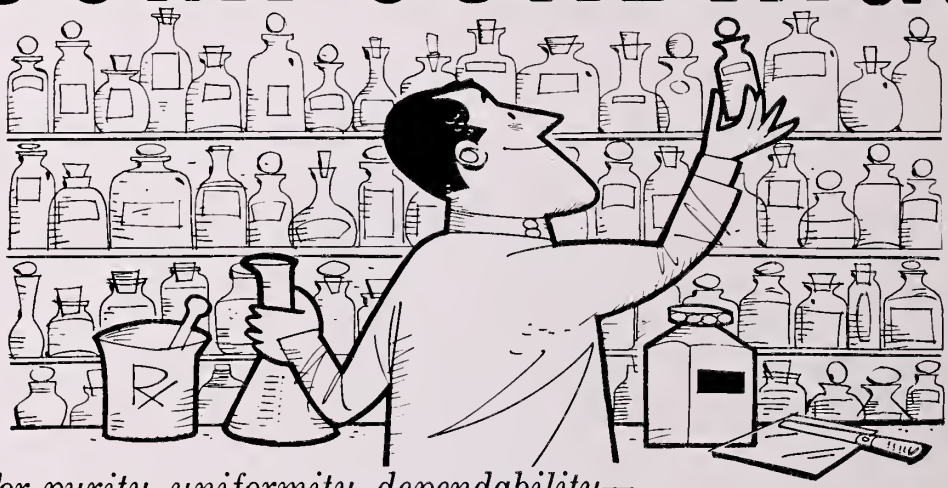
The panel on pulmonary disease brought up the point of smoking, and of course the controversy that surrounds this problem. As your delegate will inform your district, there was a proposed resolution concerning smoking that the House of Delegates was asked to adopt. I think that this is of particular importance and it must be weighed carefully by each of you. I feel that it is a matter upon which each of you must express an opinion to your delegate.

I am looking forward to visiting each of your districts, although my visit may be a hurried one. I trust that you will feel free to put problems on the line and not be particularly polite about doing so. Don't forget, it is our Association.

Best wishes to all of you.

Robert H. Hayes, M.D.
President

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For delivery of what you want, when and where you want it—

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BLUE SHIELD
CORPORATE BODY ANNUAL MEETING
MINUTES — JUNE 8, 1963

MINUTES OF THE ANNUAL BLUE SHIELD CORPORATE BODY MEETING

Kochi Motel, Yankton, South Dakota

Saturday, June 8, 1963

The meeting was called to order by the President, Dr. Paul Hohm. Present for roll call were: Drs. C. L. Vogele, R. E. Bormes, G. F. McIntosh, W. T. Sweeney, G. Robert Bartron, T. J. Wrage, Jr., Donald Scheller, J. A. Anderson, R. C. Jahraus, H. Werthmann, C. S. Swanson, F. D. Leigh, Yale Charbonneau, E. H. Mueller, C. F. Binder, R. Giebink, J. Donahoe, G. M. Jameson, A. K. Myrabo, E. W. Sanderson, C. A. Stern, S. M. Brzica, T. A. Angelos, Bill Church, R. J. Foley, T. H. Willcockson, R. Bareis, T. Jacobson, F. Gilbert, C. J. Blunck, M. R. Cosand, C. A. Johnson, V. Janavs, Magni Davidson, R. H. Hayes, A. P. Reding, C. J. McDonald, R. H. Quinn, E. J. Perry, J. J. Stransky, M. C. Tank, L. C. Askwig, Paul Hohm, Preston Brogdon, E. T. Lietzke, T. H. Sattler, J. T. Elston, E. P. Sweet, and E. A. Johnson.

A motion was made by Dr. C. J. McDonald to dispense with the reading of the minutes of the previous meeting inasmuch as they were published in the Medical Journal. The motion was seconded and carried.

Mr. Foster read the financial report for the calendar year 1962.

A report on Medicare — April, 1962 thru March, 1963 — was given by Mr. Foster.

Mr. Foster also discussed the financial report of the Old Age Assistance program from April, 1962 thru March, 1963.

A nominating committee was appointed and consisted of the following individuals: L. C. Askwig, M.D., Chairman; E. J. Perry, M.D.; P. P. Brogdon, M.D. The committee was directed to nominate four individuals to fill the regular terms on the Blue Shield Board of Directors.

The recommendations from the nominating committee to fill the directorship left vacant by Daniel Bylander per his resignation, were John C. Foster, Sioux Falls; Jesse Olson, Yankton; and Charles Burke, Pierre. The Board was directed to contact the nominees and appoint the individual willing to accept such position. The Committee recommended that Drs. Hohm, King, and Elston be re-elected to succeed themselves. Dr. Hayes seconded the nominations. Dr. Hayes moved that nominations cease and that the secretary be instructed to cast a unanimous ballot for the above named slate. Seconded by C. J. McDonald, M.D., and carried.

Dr. Hohm briefly discussed the rate increase which went into effect April, 1963.

Mr. Foster discussed the Kerr-Mills M.A.A. program which starts July 1, 1963, in South Dakota.

Mr. Foster also discussed the two Basic Blue Shield policies which have been endorsed, and mentioned the proposed student insurance plan.

Dr. Myrabo moved that the meeting be adjourned. The motion was seconded by Dr. Jahraus, and was carried.

RATE INCREASE EXPLANATION

As of April 1, 1963, South Dakota Blue Shield had a general premium rate increase of $ .20 for single subscribers and $ .40 for family.

This increase was the first to be adopted since South Dakota Medical Service was formed in 1956.

Approved by the Blue Shield Board of Directors, and the State Insurance Commissioner, the increase of $ .20 and $ .40 was based on a three year projection of claims increase.

Many factors had to be considered before the final increase was put into effect. The loss of 1.4% for 1962 was the major factor, however, the increase in the average cost per claim from $40.67 in 1958 to $51.96 in 1962, plus a decrease in pure reserves, pointed up the need for a small premium increase.

RESUME OF SOUTH DAKOTA KERR-MILLS IMPLEMENTATION PROPOSAL

The 1963 Session of the South Dakota Legislature passed legislation to implement the Kerr-Mills Law in that State for medical care for needy persons 65 years of age and over.

The action of the legislature was unique in two ways, in that it provided only enough funds to conduct a pilot program, and it establishes a prepayment system of operation.

It was the feeling of the legislature that many states had jumped into a program without any accurate estimate of the total needs. Several of these have found that their appropriations far exceeded the demand for fund utilization.

A "pilot" program will determine within a short time, the number of needy persons, the extent of their needs, and will provide a more accurate determination of the cost of a full program.

The South Dakota State Medical Association took the position that any program for persons in the "near-needy" or "medically indigent" area should be treated as nearly akin to their more fortunate (and solvent) confreres as possible. Those persons having resources protect themselves against the cost of medical-surgical and hospital care with prepaid Blue Cross-Blue Shield or insurance contracts so it was determined that persons who turned to the Kerr-Mills program as a resource should receive comparable benefits. The Legislative Committee studying the problem concurred in this view and a bill was drafted and introduced by Representative Ellen Bliss, Sioux Falls, Chairman of the House Committee on Health and Welfare.

The Bill was signed into Law by Governor Archie Gubbrud and becomes effective on July 1st or when the plan receives approval of the Department of Health, Education, and Welfare, whichever is later.

The Law empowers the State Department of Public Welfare to set up a program to qualify for Federal funds and provides that:

1. A person to be eligible for aid must not be a recipient of Old Age Assistance when he applies, must be unable to pay for medical or remedial care, must not have an average

annual income of $1,500 or more, or $1,800 for a married couple, and must not have a net worth of $10,000.00 or more. If available funds are insufficient, the Department may set lower limits on income and resources but may not go above these specified limits.

2. The Department is empowered to accept applications and determine eligibility of those who apply. All individuals wishing to do so shall receive an opportunity to apply and assistance is to be furnished with reasonable promptness to those who are eligible.
3. The Department may appoint county advisory committees to assist in recommending selection of applicants. Basic intent of this provision is to keep a local flavor to the selection where needs are best known.
4. The Welfare Department shall contract with Blue Cross and Blue Shield or licensed insurance companies to purchase pre-paid health coverage which shall include the following:
   Hospitalization is to be limited to 30 days per admission in semi-private or ward accommodations. Said provision includes a $25.00 deductible clause, out-patient hospital care and services. Physicians' services are limited to 12 office calls per fiscal year and to medical calls, surgical and other services in a hospital for 30 days per admission. Laboratory, x-ray and other special procedures may be limited to $100.00 per fiscal year. The latter procedures are subject to a $10 deductible clause. Physicians must agree in writing to participate in the plan.
5. A provision is made for the insurance company or Blue Cross-Blue Shield Plan to operate without profit or loss. A Contingency Fund was established to not only take care of the possibility of loss, but to provide services for individuals not on the program whose illness makes them eligible.
6. The usual provisions are included in the law which makes it effective simultaneously in all political sub-divisions, prohibits payment by the recipient of enrollment fees as a condition of eligibility, reserves to the State Department of Welfare the right to cancel a contract within 30 days written notice, provides safe-guards against use and disclosure of information concerning applicants for or recipients of assistance, and provides a penalty for fraudulent information given by the applicant.

The Program, as adopted by the Legislature, has the endorsement of the State Medical Association, the State Hospital Association, and other health organizations. The pre-payment aspect of the plan and the "pilot program" aspect of the plan which will curtail high administrative costs, met with high favor from most legislators and other individuals involved.

W. B. SAUNDERS COMPANY features the following new editions in their full page advertisement appearing elsewhere in this issue:

BEESON and McDERMOTT — CECIL-LOEB TEXTBOOK OF MEDICINE
The New (11th) Edition of a world-famous text, with contributions by 173 authorities and details of over 800 diseases

GRAHAM — THE CYTOLOGIC DIAGNOSIS OF CANCER
An up-to-date revision explaining what can be learned from suspected smears through accurate laboratory methods

MAYO CLINIC — CLINICAL EXAMINATIONS IN NEUROLOGY
A famous medical center's working blueprint to effective neurologic examination



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®
meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

MEDICARE
FINANCIAL REPORT

Date	Claim Cost	Administration Cost	Total	% Adm. Cost
April 1962	$ 5,953.25	$ 267.61	$ 6,220.86	4.3%
May 1962	6,543.90	255.12	6,799.02	3.7
June 1962	5,210.25	242.28	5,452.53	4.5
July 1962	4,618.16	264.67	4,882.83	5.4
Aug. 1962	5,335.00	280.09	5,615.09	5.0
Sept. 1962	4,232.25	255.84	4,488.09	5.7
Oct. 1962	5,414.50	232.28	5,646.78	4.1
Nov. 1962	4,524.75	234.89	4,759.64	4.9
Dec. 1962	5,352.25	248.05	5,600.30	4.4
Jan. 1963	4,336.31	262.03	4,598.34	5.7
Feb. 1963	3,862.50	258.35	4,120.85	6.3
Mar. 1963	3,065.50	250.22	3,315.77	7.5
Total	$58,448.62	$3,051.43	$61,500.10	61.5%
Average	$ 4,870.72	$ 254.29	$ 5,125.01	5.1%

OLD AGE ASSISTANCE PROGRAM
FINANCIAL REPORT

April 1962 Through March 1963

Balance Sheet

Assets		
a. Cash in Bank	$11,690.35	
b. Equipment	2,330.43	
c. Accts. Receivable	14.00	
Total Assets		$14,034.78
Liabilities		
a. Accts. Payable	$10,000.00	
b. W/H & Soc. Sec.	69.46	
Total Liabilities		$10,069.46
Surplus and Reserve		
a. Reserve for Dep.	$ 69.26	
b. Surplus	3,896.06	
Total Surplus and Reserve		$ 3,965.32
		$14,034.78

Income & Expense Statement

Income	
a. Claims & Adm. Income	$335,101.97
Expenses	
a. Claims Expense	313,584.92
% to Income	93.6%
b. Operating Expense	19,380.09
% to Income	5.8%
Total Expense	$332,965.01
Excess of Income over Expense	
a. Excess	$ 2,136.96
% to Income	.6%

Operating Expense

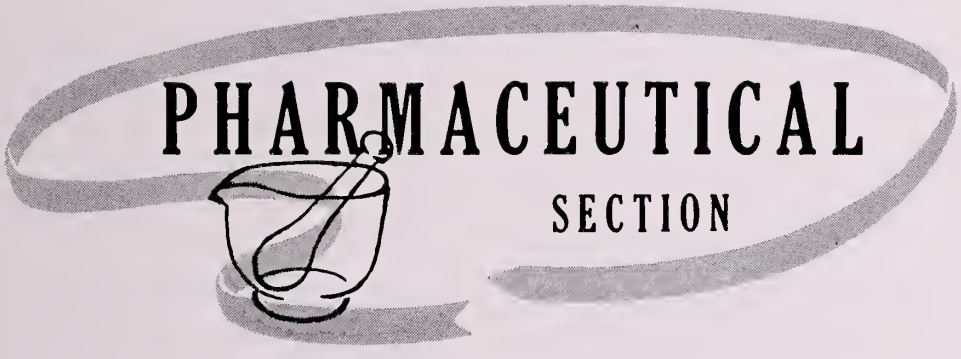
Administration Expense	
Salaries	$ 9,356.94
Social Security	151.13
Employee Relations	193.50
Audit & Legal	164.50
Equipment Rental	2,665.75
Rent	1,731.25
Postage	873.40
Supplies	1,522.73
Travel	417.59
Telephone	273.62
Payments not Reimbursed by Welfare	643.00
Review Committee	316.75
Refunds	233.57
Interest Expense	750.00
Miscellaneous	302.83
Total Expense	$ 19,380.09

BLUE SHIELD
COMPARATIVE BALANCE SHEETS
DECEMBER 31, 1961 AND DECEMBER 31, 1962

ASSETS	December 31, 1961	December 31, 1962	Increase (Decrease*)
Ledger Assets:			
Cash on hand and in bank	$ 72,168.24	$ 79,982.24	$ 7,814.00
Accounts receivable — Federal program	6,176.11	671.00	(5,505.11*)
Accounts receivable — O.A.A. program	15,000.00	15,000.00	-0-
Certificates of Deposit — First National Bank	5,000.00	5,161.38	161.38
Certificates of Deposit — Farmers and Merchants Bank	10,000.00	10,000.00	-0-
Certificates of Deposit — Western State Bank	10,000.00	10,000.00	-0-
Certificates of Deposit — American National Bank	10,000.00	10,000.00	-0-
U. S. Government — Treasury note	10,256.52	10,256.52	-0-
Stock — Rushmore Credit Corporation	1,000.00	1,000.00	-0-
Mortgage Loan — S. D. Medical Association	23,939.77	23,101.88	(837.89*)
Total Ledger Assets	**$163,540.64**	**$165,173.02**	**$ 1,632.38**
LIABILITIES AND RESERVES			
Liabilities:			
Accrued State of South Dakota premium tax payable	$ 2,332.14	$ 2,747.30	$ 415.16
Withholding tax payable	352.60	462.28	109.68
Social security tax payable	24.29	42.96	18.67
Advance payment — Federal Employees program	7,000.00	7,000.00	-0-
Total Liabilities	**$ 9,709.03**	**$ 10,252.54**	**$ 543.51**
Deferred Income:			
Unearned subscribers dues	$ 35,349.27	$ 41,686.00	$ 6,336.73
Reserves:			
Estimated claims — not reported	$ 40,000.00	$ 45,000.00	$ 5,000.00
Surplus — Unassigned	$ 78,482.34	$ 68,234.48	($10,247.86*)
Total Liabilities and Reserves	**$163,540.64**	**$165,173.02**	**$ 1,632.38**

COMPARATIVE STATEMENTS OF INCOME AND EXPENSES
YEARS ENDED DECEMBER 31, 1961 AND DECEMBER 31, 1962

	December 31, 1961	December 31, 1962	Increase (Decrease*)
Receipts:			
Earned subscription income	$605,705.28	$718,237.67	$112,532.39
Interest earned	2,561.84	2,759.66	197.82
	$608,267.12	$720,997.33	$112,730.21
Medical and Surgical Expenses:			
Participating physicians	$357,406.97	$457,310.09	$ 99,903.12
Non-participating physicians	115,477.58	138,570.08	23,092.50
	$472,884.55	$595,880.17	$122,995.62
Operating Expense:			
Salaries	$ 24,326.92	$ 33,889.56	$ 9,562.64
Travel expense	5,713.82	6,466.34	752.52
Rent	3,960.00	3,999.90	39.90
Board meeting expense	591.21	768.20	176.99
Boards, bureaus and associations	1,073.08	1,361.59	288.51
Legal expense	999.96	999.96	-0-
Printing and stationery	4,773.67	4,214.59	(599.08*)
Books, newspapers and periodicals	12.00	22.00	10.00
Postage	1,311.68	1,282.92	(28.76*)
Telephone and telegraph	1,615.57	1,442.38	(173.19*)
Advertising	4,778.31	5,632.73	854.42
Insurance	126.96	168.45	41.49
Employee relations	460.33	3,367.70	2,907.37
Auditing, actuarial and consulting	353.70	615.94	262.24
Outside service agencies	47,291.65	63,903.22	16,611.57
Miscellaneous expense	33.19	47.69	14.50
Social security tax expense	551.75	799.15	247.40
Taxes — licenses and fees	3,771.49	3,903.24	131.75
Furniture and equipment expense	5,134.40	7,535.19	2,400.79
	$106,879.69	$140,420.75	$ 33,541.06
Less — reimbursements	2,788.00	10,055.73	7,267.73
Net Operating Expenses	$104.091.69	$130,365.02	$ 26,273.33
Total expenses	$576,976.24	$726,245.19	$149,268.95
Net Operating Income or (Deficit)	$ 31,290.88	($ 5,247.86)	($ 36,538.74*)
Other Charges or Credits:			
Estimated reserve for unreported services	7,000.00	5,000.00	(2,000.00*)
Net Gain or (Deficit) to Surplus Unassigned	$ 24,290.88	($ 10,247.86)	($ 34,538.74*)



GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota

Transactions of the South Dakota Pharmaceutical Association Annual Convention June 23, 24, 25, 1963 Pierre, South Dakota

PRESIDENT'S ADDRESS

L. B. Urton, President
Sturgis, South Dakota

Officers and Members of the South Dakota Pharmaceutical Association, honored guests, ladies and gentlemen.

Just one year ago it was my privilege to be elected president of your Association. It has been an active, interesting, and educational year for me, and a year I will cherish and long remember.

I have been very fortunate to have had an excellent Executive Committee made up of people with whom it has been a pleasure to serve. They have never failed to help and to advise during a somewhat hectic year. Secretary Bliss Wilson has at all times assisted me in every way, and I wish at this time to especially thank Bliss for all the extra work he has done for me.

Last February Chairman Zarecky requested that I be ready with six speeches, so I prepared six speeches. In April he said four speeches would suffice, and late in May he informed me I would have only one spot on the program. So, I have condensed the six speeches into one 16-page report. Now if any of you get through before I do, please leave quietly.

I could give you a patriotic speech -- the Patrick Henry type — but I know you are all patriotic. Or I could give you a William Jennings Bryan type — real political oratory — but I am ahead of him. Mr. Bryan ran for president twelve times and lost. Or maybe you would prefer the double-talk of Mark Anthony. But, I did not come to Pierre to bury "Old Red," and an inborn modesty will not permit me to praise him.

Having just completed my fortieth year in the practice of pharmacy, it is quite evident that I like my work and am very proud of my profession. I have seen many changes in the professional use and merchandising of drug products. Most of these changes have been for the better. It has at times been difficult to adjust to these changes, and my observation has been that those who refuse or are unable to adjust to changing methods, do not survive.

We have the advantage of having dedicated young men and women entering the profession of pharmacy each year. These new members bring new ideas and new vigor, which is refreshing and beneficial to our profession. I urge each member to make the best use of this fountain of youth for your business and your Association. Without this stimulation, your business and your Association will become complacent and stagnate.

Being one of your delegates to the N.A.R.D. Convention in New York City meant many firsts for me: my first airplane trip, first boat trip and my first tour of New York City. The Convention was a pleasure and an education. Serving on the Resolutions Committee was quite an experience. I hope the time will come when this Association can afford to send all of the vice presidents as delegates.

I have five recommendations for your consideration:

1. Direct buying is a matter that is being forced upon us by the manufacturer at the price the wholesaler pays, but in quantities greater than our businesses warrant, in order to qualify for direct shipment. This arrangement virtually eliminates the possibility of the wholesaler competing in today's market.

It is unjust to the wholesaler and to the average independent retailer. I firmly believe that the wholesaler fills an important need in our system of free enterprise, and that the independent retailer cannot survive without the wholesaler. I consider the wholesaler's interest in the success of my business as one of my best assets. We are the ones vitally concerned, and we can do something about it now. I would urge positive action in the form of a resolution condemning this practice of direct buying at this Convention.

2. I also would urge the adoption by this Convention of a resolution endorsing the Quality Stabilization Bill with which you are all familiar.

3. I favor the adoption of a resolution to bring our pharmacy laws up to date, eliminate those that are outmoded, and authorize the Board of Pharmacy to recommend new pharmacy laws that can be enforced.

4. I favor endorsing the stand taken by the N.A.R.D. and Secretary Willard Simmons, to oppose the ruling by the A.M.A. that "Drugs, Remedies, or Appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient."

5. Our public relations work the past three months has been well received with reprints appearing in many of our local weekly newspapers. It has exceeded our fondest expectations, and I hope this work will be greatly expanded during the next year.

Thank you very much for making my tenure of office so pleasant.

REPORT OF THE SECRETARY SOUTH DAKOTA STATE PHARMACEUTICAL ASSOCIATION AND SOUTH DAKOTA STATE BOARD OF PHARMACY

Bliss C. Wilson, Secretary
Pierre, South Dakota

Mr. President, Fellow Pharmacists and Guests:

It is my duty to report to this annual meeting regarding the financial status of the Board of Pharmacy and the Association's accounts; to report on the members who are in good standing, the pharmacies that have paid dues to the Commercial and Legislative Section and the number of permits and licenses issued by the Board of Pharmacy. I shall cover these items as briefly as possible so they may be included in the annual proceedings.

At their meeting on March 24, 1963, the Executive Committee re-employed the accountant firm of Keenan and Craig to audit the books and records of the Secretary and Treasurer for the 1962-1963 fiscal year. Their audit report for the period June 1, 1962, to May 31, 1963, shows the Secretary's receipts to the Association's General Fund account of $9,511.00 and to the Commercial and Legislative Fund of $5,703.74. The Secretary's receipts for the Association totaled $15,214.74. Warrants were drawn on the General Fund in the amount of $10,233.00 and on the Commercial and Legislative Fund of $5,830.05 for total disbursements of $16,063.05. A loss in the Association's cash balances is shown at $848.31.

In the Board of Pharmacy account, the Secretary's receipts totaled $16,481.00. Warrants drawn on the Board of Pharmacy account totaled $15,871.67. The audit report for the State Board of Pharmacy shows a gain in net worth of $609.33.

SOUTH DAKOTA PHARMACEUTICAL ASSOCIATION MEMBERSHIP REPORT

Pharmacists in good standing on June 18, 1962		956
ADD: Reinstated by renewal payments	2	
Registered by reciprocity	1	
Registered by exams Jan., 1963	8	
Registered by exams June, 1963	20*	
		31
		987
SUBTRACT:		
Deceased members	7	
Renewals unpaid for 1962-63	19	
To honorary membership	4	
		30
Pharmacists in good standing on June 24, 1963		957

CERTIFICATE RENEWALS RECORD

1962-63 Renewals Paid to June 24, 1963	918
1962-63 Renewals FREE to Armed Forces	14
Certificates valid to October 1, 1963	9
Certificates due on June, 1963, examinations	20*
	961
Deceased members who paid 1962-63 renewals	4
Certificates accounted for to membership on June 24, 1963	957

The certificate of one assistant pharmacist is in good standing.

COMMERCIAL AND LEGISLATIVE SECTION PHARMACY MEMBERS

Pharmacies that paid member dues for 1963 to June 24, 1963	149
Pharmacies that paid member dues for 1962 to June 18, 1962	144
Increase in membership up to convention time	5
Thirty-four pharmacies paid 1962 member dues after last year's convention bringing the total of voluntary members at $8.00 each to	178

*Subject to correction after grade reports.

There were 240 pharmacies registered as of November 30, 1962, making a total of over 70 percent of eligible businesses who contributed to our voluntary funds account.

DONATIONS

Pharmacies donated $86.00, other than for membership dues, to the Commercial and Legislative fund during the past year. The Sioux Falls convention receipts, including donations by manufacturers, amounted to $3,165.00 which was approximately $1,000.00 more than the convention expenses.

RESTRICTED DRUG LABELS

In April, 1962, the Executive Committee authorized the purchase of two hundred thousand Monarch labels bearing the imprint "RESTRICTED DRUG ITEM" for use in conjunction with the 1962 directive of the Board of Pharmacy. Inspector Harry Lee took charge of the distribution and sale of these label rolls to drug stores so that it was necessary to order an additional two hundred thousand. The net profit to the Commercial and Legislative fund from this venture was $78.90.

VETERANS' ADMINISTRATION SERVICE

This Association's contract with the Veterans' Administration for processing VA prescriptions was terminated on December 31, 1962. Receipts to the Commercial and Legislative fund from this source was $150.13 during the past year.

BOARD OF PHARMACY RECORDS

Permits To Conduct Pharmacy

Pharmacy permits effective on June 18, 1962	241
Permits not renewed for 1962-63 year	4
Permits renewed for 1962-63 year	237
NEW pharmacies established during 1962-63	4
Total permits issued for 1962-63	241
Pharmacies discontinued during 1962-63	3
Pharmacy permits effective on June 24, 1963	238

Household Remedy Licenses

1962-63 HHR Licenses issued to June 30, 1963	136
1961-62 HHR Licenses issued to June 1, 1962	134
Increase	2

Poison Licenses

1963 Poison Licenses issued to June 1, 1963	764
1962 Poison Licenses issued to June 1, 1962	690
Increase	54

Patent Medicine Licenses

1962-63 Patent Licenses issued to June 1, 1963	2,315
1961-62 Patent Licenses issued to June 1, 1962	2,313
Increase	2

Reciprocity

1962 Reciprocity from S. Dak. by Grade Fees	23	
Reciprocity to S. Dak. by Registration	5	
Difference		18
1962-63 Reciprocity from S. Dak.by Grade Fees	27	
Reciprocity to S. Dak. by Registration	1	
Difference		26
Increase		8

At our Sioux Falls convention, last year, this Association resolved that in order to effect a reasonable compromise in regard to the Board of Pharmacy regulation concerning restrictive sale of veterinary injectables, that we present the following plan: "Issue to properly qualified, non-pharmacist, individuals a special license to vend all animal remedies including those stated in the Rules and Regulations of the South Dakota State Board of Pharmacy, Section K — Patent and Proprietary Medicines, subsection '(2)' and '(3)' under '(b)' of regulation numbered "8." This license to be awarded only to those individuals who properly qualify under a set of rules and examinations as set forth by the South Dakota State Board of Pharmacy. This examination should be adequate to determine that the applicant has knowledge pertinent to all the facets of proper handling and vending of these products. Be it further resolved that a committee be appointed by the president of the Association to meet with interested animal remedy consumer groups to discuss legislation in this regard."

To implement this resolution which may be considered a mandate of our Pharmaceutical Association, this office, with the assistance of our attorney, formulated a proposal to amend our state pharmacy law by adding a new section thereto to be numbered "27.1020." This proposal, which most of the pharmacists in the state have never seen, included all of the provisions as set forth in the resolution quoted above. The proposal provided that: "On or after, November 1, 1963, any person, not a registered pharmacist or licensed veterinarian, of good moral character and temperate habits, not less than twenty-one years of age, who shall pass a satisfactory examination prescribed by the State Board of Pharmacy on the retailing and use of restricted animal remedies shall be entitled to a certificate from the State Board of Pharmacy as an animal remedies registrant for the year ending December 31st."

This personal certificate was to be renewed annually "for any year in which such registrant will be engaged in the retailing of restricted animal remedies." The original proposal provided that: "the State Board of Pharmacy shall issue to animal remedies registrants in good standing, a permit to conduct an animal remedies department," regardless of the location. A majority of the Executive Committee recommended that the original proposal be changed so that an animal remedies department would not be situated less than eight miles from a registered pharmacy.

For the protection of public health and safety, the proposal provided that: "No permit shall be issued under this section unless — (1) The animal remedies department maintains facilities for closing such department for the transaction of business whenever an animal remedies registrant or a pharmacist or veterinarian, is not on duty and in charge thereof, or (2) A poison register is maintained as provided by law, or (3) Refrigerated storage space for medicines affected by extreme temperatures is maintained within such animal remedies department." The permit to conduct an animal remedies department would have been subject to cancellation if kept open without a qualified individual on duty, or if not maintained in a clean and sanitary condition, or if broken packages, or deteriorated, or out-dated medicines are not removed from stock displayed for sale to the public. This proposal would have permitted retail sales, within such animal remedies department, of all drugs and medicines in the original packages which are labeled for use for animals other than man, except those restricted by federal law to sale by or on the order of a licensed veterinarian.

It is my own personal opinion, that if such a proposal had been introduced in the 1963 session of the legislature by the Public Health Committee or by an individual legislator who is interested in the protection of public health and safety, then, such a bill might have been enacted into law as recommended in the resolution passed by our Association in 1962.

The special Veterinary Committee appointed by President Urton was also designated as the committee to meet with interested animal remedy consumer groups to discuss legislation in this regard. Chairman Carveth Thompson will report to this convention at our closed session tomorrow forenoon. President Urton, Carveth Thompson and I drove to Belle Fourche where we explained the provisions of our proposal for an animal remedies law in South Dakota as approved by the Executive Committee of our Association, to members of the governing body of the South Dakota Livestock Growers' Association. It is evident that this consumer group was not interested in the provisions of our proposal for the protection of public health and safety in the retailing of animal remedies.

Senate Bill No. 26 as introduced by Mr. Ramey would have authorized the sale of all drugs or medicines of every kind for the care and advancement of the health of animal livestock by persons licensed by the Secretary of Agriculture and repealed all provisions of law which heretofore may have restricted such sale and were in conflict with the provisions of Senate Bill No. 26. There were no restrictive provisions in the Bill whatsoever. If enacted, it would have repealed all of the important provisions of our State Pharmacy Law, Poisons Law, Barbiturate Law and Uniform Narcotics Law. I mentioned these objections to the Senate Agriculture Committee at the first hearing on the Bill. This was my first, last, and only contact with the 1963 session of the legislature. From here on, lobbying against this measure was handled exclusively by other members of our Association. They are to be congratulated for their efforts through which Senate Bill No. 26 was killed in Committee. A Legislative Committee Report will be given at the Tuesday morning session.

As Secretary of the Board of Pharmacy, we have continued our policy of sending certified mail, return receipt, letters to violators against whom we have evidence of pharmacy law violation in the use of the word "drug" in printed advertisements, or invoices of sales, at wholesale, of restricted drug items which the retailer is not licensed to re-sell. In every instance, so far, the Board of Pharmacy office has received satisfactory replies within ten days of the receipt of the certified mail notice. Neither have we found any general merchant, so far, who has challenged the Board of Pharmacy against the removal by our Inspector, of restricted drug items from stock displayed for sale. The Board of Pharmacy is prepared to defend any such challenge, only, so long as, every pharmacy manager maintains segregated displays and regulated sales of such items within the drug stores of our state.

A pocket dictionary defines the word DUTY as "What the average man looks forward to with distaste, does it with reluctance, and boasts about forever after." No doubt, some pharmacy managers are still regarding the 1962 Directive with distaste. Others are reluctant to designate to the public that portion of the drug store which is professional. One pharmacist, with his DUTY performed, was so proud of his professional area and his method of designating the floor space, that he invited Harry and me to come and take pictures of his arrangement. The pictures are on display at this convention. The idea of designating the floor space may be adaptable to your drug store.

Since our 1954 convention in Aberdeen, when this Association resolved that the Board of Pharmacy be requested to formulate regulations governing the retailing of packaged drugs and medicines within the registered pharmacies of this state, I have considered it my DUTY to formulate proposals for regulations governing pharmacists, whereby the public health would be protected in accordance with the decision of our Supreme Court in the case "State vs. Wood."

After due notice, the members of this Association have approved many of these proposals and recommended their adoption by the State Board of Pharmacy as its official rules and regulations governing registered pharmacists. It was more than four years (October 20, 1958) before the Board of Pharmacy finally adopted the Anti-Self-Service Regulations. Not until then, was it possible to refuse the registration for a NEW pharmacy that is owned by a non-pharmacist or a corporation, and include floor space where general merchandise is displayed and offered for sale. Only this past week, I had a phone call from an attorney representing a chain drug store corporation that was interested in establishing outlets in South Dakota. When he learned that permits to conduct a pharmacy were granted only to individual pharmacists who had been delegated full and complete authority to be in active management of drugs, medicines and poisons and that no place or space other than the prescription department and the restricted drug area could be registered as a pharmacy and that walls from the floor to the ceiling had to separate the pharmacy from the general merchandise store which would not be permitted to use the word "drugs" in its advertisements and signs, he indicated that South Dakota was not the state where his client was likely to expand. I mailed him a copy of our laws and regulations and an application for the registration of, and for a permit to open and conduct a new pharmacy but I don't think it will ever be completed and filed.

After twenty-two years of service which I hope has added to the advancement of our profession, I feel I have done my "DUTY" in implementing the resolutions of this Association to the best of my ability. I have written President Urton expressing my willingness to retire at the pleasure of the Executive Committee.

REPORT OF THE TREASURER SOUTH DAKOTA PHARMACEUTICAL ASSOCIATION

J. C. Shirley, Treasurer
Brookings, South Dakota

GENERAL FUND ACCOUNT

Balance in Northwestern National Bank, Brookings, South Dakota, June 1, 1962	$ 2,483.27
Receipts	9,511.00
	11,994.27
Disbursements	10,233.00
Cash Balance as of June 3, 1963	1,761.27
Balance in Bank, June 3, 1963	1,761.91
Add charge of C. & L. Warrant No. 776 in error	25.68
Erroneous charge	25.68
Less Outstanding Warrants	None
	1,813.27
Deduct deposit of C. & L. fund receipt in error	(52.00)
Balance with Treasurer June 3, 1963	$ 1,761.27

COMMERCIAL AND LEGISLATIVE FUND

Balance in Northwestern National Bank, June 1, 1962	$ 727.29
Add Receipts from Donald Knutson to be included in 1961 Convention	308.50
	1,035.79
Receipts from Bliss C. Wilson, Secretary	5,703.74
	6,739.53
Less Warrants Paid	5,830.05
Balance	909.48
Balance in Bank, June 3, 1963	918.84
Add Deposit of 4-2-63 to General Fund in error	52.00
	970.84
Deduct:	
Outstanding Warrant No. 521 — Bonnie Stenrud	(10.00)
Warrant No. 766 to General Fund in error	(25.68)
Erroneous Credit	(25.68)
Balance	$ 909.48

REPORT OF THE TREASURER SOUTH DAKOTA BOARD OF PHARMACY

J. C. Shirley, Treasurer
Brookings, South Dakota

Balance in Northwestern National Bank, Brookings, South Dakota, June 1, 1962		$ 2,387.17
Cash Receipts		16,481.00
		18,868.17
Disbursements		15,871.67
Cash Balance — May 31, 1963		2,996.50
Balance in Bank — as of statement June 3, 1963		3,006.50
Less Outstanding Checks:		
No. 3943 W. L. Schugel	5.00	
No. 4037 Lillie Anderson	5.00	
	10.00	10.00
Balance with Treasurer on June 3, 1963		$ 2,996.50

ANNUAL REPORT OF SOUTH DAKOTA STATE BOARD OF PHARMACY

T. E. Hustead, President
Wall, South Dakota

Honorable Archie M. Gubbrud
Governor of South Dakota
Pierre, South Dakota

The South Dakota State Board of Pharmacy submits the annual report of its activities for the fiscal year beginning June 19, 1962, and ending June 25, 1963. The Board of Pharmacy held six official meetings during this past year.

The first meeting was held at Sioux Falls on June 19, 1962, following adjournment of the seventy-sixth annual meeting of the South Dakota Pharmaceutical Association. Theodore E. Hustead was elected as delegate to represent the South Dakota Board of Pharmacy at the 1963 Annual Convention of the National Association of Boards of Pharmacy to be held in Miami, Florida. The Board approved the application of Alfred Kleinsasser for the registration of and for a permit to open and conduct a NEW pharmacy as "Kleinsasser Drug" in Freeman, South Dakota. A similar application for the registration of a NEW pharmacy in Sioux Falls was ordered to be held until a future date and after the building which was to house the new pharmacy has been completed.

The Board of Pharmacy held its second meeting in conjunction with the Fifth District Meeting of Boards and Colleges of Pharmacy at Lincoln, Nebraska, on September 30, 1962. Dr. Floyd J. LeBlanc and Dr. Kenneth Redman of the Division of Pharmacy at South Dakota State College, who were in attendance at this district meeting, were invited to meet with the Board of Pharmacy for discussions regarding a proposal to amend the South Dakota Pharmacy Law to provide for the retail sale of restricted animal remedies by persons other than registered pharmacists and as recommended by the South Dakota Pharmaceutical Association in a resolution adopted at its last annual meeting in Sioux Falls.

The third meeting of the Board was held at Pierre on October 7, 1962. Pharmacist Thomas K. Haggar of Watertown presented credentials of his appointment by your office to membership on the South Dakota Board of Pharmacy for a term of three years ending September 30, 1965. T. E. Hustead was elected president of the Board of Pharmacy for the ensuing year. Dates for licentiate examinations to be conducted at the Division of Pharmacy, South Dakota State College, during the 1963 calendar year, were set for January 8, 9, 10, 1963, and June 4, 5, 6, 1963. The secretary was instructed to contact pharmacy college graduates announcing such examination dates and to request information as to when they might be expected to appear for Board of Pharmacy examinations for licensure.

The fourth meeting of the fiscal year was held at Brookings starting January 8, 1963. Only eight pharmacy college graduates appeared at this meeting for Board of Pharmacy examinations for licensure. With this limited number of candidates, the Board members were able to conduct all of their examinations within a two-day period rather than three days as previously scheduled. William R. Hoel appeared at this meeting for final consideration of his Reciprocity Application No. 63-0498 from North Dakota. Certificates of Licentiate in Pharmacy, dated January 9, 1963, were granted as follows:

Cert. No.	Pharmacist	Address
R-3469	William R. Hoel, B.S.	Huron, S. Dak.
3470	Gary Bell, B.S.	Wessington Springs, S. Dak.
3471	Sharon L. Berkner, B.S.	Milbank, S. Dak.
3472	Kenneth W. Bray, B.S.	Aberdeen, S. Dak.
3473	Judy Cullen, B.S.	Chamberlain, S. Dak.
3474	B. Judith Hladik, B.S.	Rapid City, S. Dak.
3475	Sharon K. Krebs, B.S.	Wakonda, S. Dak.
3476	Jon Charles Lee, B.S.	Clarkfield, Minnesota
3477	Barbara Elms Underhill, B.S.	Aberdeen, S. Dak.

During the 1963 legislative session, the members of the Board of Pharmacy spent considerable time in Pierre opposing Senate Bill No. 26 relating to the sale of all drugs and medicines of every kind for the care and advancement of the health of animal livestock by persons licensed by the Secretary of Agriculture and repealing all provisions of law which heretofore may have restricted such sale. To remove the demands for such legislation, the Board of Pharmacy held its fifth meeting of the fiscal year at Pierre on February 1, 1963, at which time the Board repealed that portion of Regulation numbered "8" under Section K — Patent and Proprietary Medicines and relating to veterinary injectables. The amended Rule and Regulation reads as follows:

8. The Board of Pharmacy hereby exempts from regulated display and regulated sale by pharmacists:

(a) Any medicine in the original package intended for use by man which is prepared or compounded in proprietary form and advertised directly to the public for self-medication and which medicine is neither an exempt-narcotic or barbiturate preparation; and

(b) Any medicine in the original package intended for veterinary use which is prepared or compounded in proprietary form and which medicine is NOT labeled with the word "POISON" for shipment in interstate commerce.

The final meeting of the fiscal year was held at Brookings on June 4, 5, 6, 1963, for the purpose of conducting licentiate examinations. Twenty pharmacy college graduates who had completed their practical experience requirements were admitted to these examinations. The grade reports for these examinations will be certified to the secretary's office following this convention. The names and certificate numbers of all successful candidates will be printed in the 1963 proceedings.

REPORT OF VETERINARY INTERPROFESSIONAL RELATIONS COMMITTEE

Carveth Thompson, Chairman
Faith, South Dakota

A proposed new animal remedies law for the regulation and sale of restricted animal remedies and the issuance of permits for such sale, was endorsed by our Association by resolution No. 10 at our last year's convention in Sioux Falls.

President Urton appointed a special Veterinary Interprofessional Relations Committee to meet with the Veterinary Medical Association and other groups as needed for the purpose of improving relations between the two associations and discussing the proposed new Animal Remedies Law.

Our Association committee consisted of:
Carveth Thompson, Faith, Chairman
John Nelson, Arlington
Lloyd Wagner, Marion
George Minard, Philip
T. C. Rutherford, Winner

The chairman met with the Executive Committee of our Association in Pierre on October 7, 1962. The Executive Committee voted at this time to add a mileage limit to the proposed bill and directed the VIPRC to meet with representatives of the Veterinary Medical Association to get their opinions on this measure.

On October 14, 1962, our committee, along with our secretary, Mr. Wilson, and our attorney, Mr. Goldsmith, met with representatives of the Veterinary Medical Association in Pierre. Present were Doctors Caley, Duncan and Severson and their attorney, John Zimmer. The proposed Animal Remedies Law was gone over and the needs for same were discussed. Their attorney, Mr. Zimmer, explained that he felt we were tackling some items (vet legend drugs) that were already covered by Food and Drug Administration regulations. He felt it would be better to get evidence of the sale of these items contrary to federal law and turn this evidence over to the FDA and let them prosecute some of these cases producing a "scare effect" on the balance of the general animal remedies dealers in the state. Mr. Wilson was asked to contact the FDA for their specific regulations pertaining to veterinary drugs, a list of the classes of veterinary drugs required to bear the vet legend and the type of evidence needed to prove federal law violation.

Mr. Zimmer commented, "Let's get the existing federal laws enforced first, before making new

ones of our own that will be equally hard to enforce." Also, the veterinarians felt our proposed bill should prohibit the licensed animal remedies registrants from traveling from farm to farm selling restricted animal remedies. The proposed bill in itself was not discussed at too much length as it was plain to see they were not ready to give us much support until the federal laws were enforced and the remaining responsibility narrowed down.

The meeting, however, was very cordial and the doctors seemed pleased to have been invited and seemed to appreciate the fact that the barrier had been broken between the two associations and professions. They also expressed a desire for another meeting as soon as we have the facts on existing federal laws. However, they did not, in any way, offer to help shoulder the responsibility for improving the present condition of indiscriminate distribution of animal health products in South Dakota.

The chairman was asked to accompany the Association president and secretary to the South Dakota Stockgrowers' meeting in Belle Fourche. This meeting has already been covered in the President's address and the report of the Secretary.

REPORT OF THE COLLEGE OF PHARMACY COMMITTEE

James F. Rogers, Chairman
Pierre, South Dakota

Mr. President and Members of the South Dakota Pharmaceutical Association:

The members of the College of Pharmacy Committee are James F. Rogers, Harold Bittner and Stanford D. Schmiedt.

Enrollment in the College of Pharmacy was approximately the same as it was last year. At the present time, it looks as if the enrollment this coming fall will be considerably higher than it has been due to an increase in the entering class.

Forty-eight seniors received their B.S. degree in pharmacy on June 3. Eight of the graduates had completed their practical experience and took the State Board of Pharmacy examinations on June 4, 5, and 6.

The demand for graduates of the Division continues and all graduates have secured good positions. In June, 1964, the Division will have no graduates because the last of the four-year students graduated this year, and the first class of five-year students will not have completed the requirements for graduation until June, 1965.

The South Dakota Board of Pharmacy and the South Dakota Pharmaceutical Association have for many years each given a tuition scholarship to worthy, entering pharmacy students. We recommend that these two scholarships be continued.

Last year the Division of Pharmacy lost two of its faculty members. Dr. Gerald Bruno, a graduate of Purdue University, will replace Dr. Stanley Shaw. Dr. Robert Knott, a graduate of Oregon State University, will replace Dr. Norval Webb. Both of the above men have had considerable experience and will prove to be valuable additions to the staff.

Construction of the new Science Building has started and it will be ready for occupancy in September, 1964. The Division of Pharmacy will have an entire floor in the new building and will retain most of the space now occupied in the Administration Building.

The following awards were made to members of the graduating class: The Merck & Company Award to Cornelius Maris; the Bristol Award to Warren Verdeck; the Johnson & Johnson Award to Kenneth Buck; the Lehn & Fink Gold Medal Award to Marlene Wallace; and the Rexall Award to Lola Schuman.

REPORT OF EARL R. SERLES MEMORIAL SCHOLARSHIP AND LOAN FUND

Floyd J. LeBlanc, Dean
Division of Pharmacy
South Dakota State College

Mr. President and Fellow Pharmacists:

The committee is sorry to report that the E. R. Serles Memorial Scholarship and Loan Fund is not growing very fast. This past year there was one memorial in the amount of $5.00 and one donation in the amount of $10.00 added to the Fund. The committee wants to re-emphasize, at this time, that anyone may make a contribution to the Fund in memory of a deceased pharmacist or they may make a personal contribution.

In the seven years that this Fund has been in existence, we have received interest in the amount of $604.95. This interest may be used for scholarships. No scholarships have been awarded up to this time, because the committee decided there should be enough money in the interest fund so that when a scholarship was awarded it could be made an annual scholarship. The interest fund now contains enough money, together with the added interest available each year, to allow the committee to award one scholarship annually. The first scholarship will be awarded for the 1963-64 year.

Loans

	Amount	Paid	Due
Nickander, Rodney	$100.00		$100.00
Youells, Richard	80.00		80.00
Thompson, Robert	200.00		200.00
Totals	$380.00		$380.00

Present Assets

Total assets 1961-62 Report		$4,175.13
Interest 1962-63 Building & Loan		127.50
Interest on loans — Bartholomew	$12.00	
Thompson	$ 8.00	20.00
Donations		15.00
Total Assets		$4,337.63
The above assets are accounted for as follows:		
Deposit Building & Loan		$3,283.41
Cash in Bank		674.22
Loans outstanding		380.00
Total assets June 6, 1963		$4,337.63

The interest, which is included in the total assets, and which may be expended for scholarships, is listed below as a matter of record:

1957-58 Report	$ 39.53
1958-59 Report	67.16
1959-60 Report	102.42
1960-61 Report	117.80
1961-62 Report	130.54
1962-63 Report	147.50
Total interest	$604.95

Memorials 1962-63

Floyd Tabor	
Mrs. E. R. Serles	$ 5.00
E. R. Serles	
George Bartholomew	10.00

The committee is made up of Gerrit Heida, W. G. Ray, and Floyd J. LeBlanc.

REPORT OF N.A.R.D. CONVENTION

Wayne Shanholtz
Mitchell, South Dakota

It is remarkable what some people will do in order to get up before a group of people. I traveled half way across the United States, sat through four days of meetings, and rode a lot of miles in a subway for the privilege of being up here today.

However, we enjoyed every minute of it. Red Urton and his wife helped make our stay in New

York much more enjoyable. I would say Red is sort of a South Dakota Herb Shriner — only better. I always feel better after talking to him.

President Red especially enjoyed the convention. I have a picture to prove it. This is Red; this is Miss Universe.

I have here the main parts of four days of speeches. You can read them in the **N.A.R.D. Journal.**

Let me say that I was very impressed with the new N.A.R.D. Secretary. He is level-headed and down-to-earth. You can be sure that he is working for the interests of the retail druggist at all times.

REPORT OF THE PHARMACEUTICAL EDITOR SOUTH DAKOTA JOURNAL OF MEDICINE AND PHARMACY

Guilford C. Gross
Brookings, South Dakota

Mr. President, Members of the Association:

During the past year, the format of the Pharmaceutical Section of the **South Dakota Journal of Medicine and Pharmacy** was kept essentially the same as that used in previous years. Each edition usually contained one or two papers on pharmaceutical topics, a section titled "Advances in Drug Research," president's page, editorial page, and a news section. Selection of papers was based primarily on what I thought would be of interest to you as members of this Association and ones which would not ordinarily be readily available to you through other media. Consideration was also given to presenting variety in the topics that appeared from issue to issue.

The news section continues to be somewhat disturbing to me in that I feel there are many news stories that would be of interest to you but which do not come to my attention. In this regard, however, Inspector for the Board, Harry Lee, has been of valuable assistance in gathering news from around the state. But, I would like to urge each of you to send me news items. You do not have to write these up in final form since that is part of my function as your editor. All I need is the information. You may be sure your help will be very much appreciated.

I wish to acknowledge the fine cooperation I have received during the past year from various members of the Association and especially that from President L. B. Urton, Secretary Bliss Wilson, and Harry Lee.

Again, I express the hope that you are reading and enjoying the **Journal** and that you are finding it informative. This is your journal and, as your editor, I will always welcome and appreciate any suggestions you may have for improving its contents.

REPORT OF THE RESOLUTIONS COMMITTEE

Mel C. Holm, Chairman
Redfield, South Dakota

Mr. President, Members of the Association:

Your Resolutions Committee, composed of Nina Lund, Mel C. Holm, and Earle Crissman, have resolutions to present at this time. With your permission, I would like to present the first five resolutions as a group:

1. Resolved that we extend a vote of thanks to A. H. (Red) Zarecky, general chairman and local secretary, his committees, the Pierre pharmacists and their good wives, and Allied Drug Travelers who have made this fine convention possible.

2. Resolved that this Association extend a vote of thanks to all manufacturers and wholesalers who contributed prizes, cash, and exhibits to this convention.

3. Resolved that this Association extend a vote of thanks to the groups and firms for their generous provision of foods and hospitality.

4. Resolved that this Association extend a vote of thanks to the following speakers who appeared on our convention program:

Rev. E. H. Hirrschoff
Hon. Governor Archie Gubbrud
Hon. Sigurd Anderson
Mayor John Griffin
B. O. Lindbloom, M.D.
Joe Cholik
John W. Hamilton
George W. Smith
Clarence Loucks
H. S. Thomas
Mrs. Lloyd Wagner
Rev. Nolz
and all those who contributed to the Memorial Hour.

5. Resolved that this Association extend a vote of thanks to Theodore E. Hustead for his service to the Board of Pharmacy.

6. Resolved that the Veterinary Interprofessional Relations Committee be continued for another year.

7. Resolved that this Association grant a $198.00 pharmacy scholarship from the Association General Fund Account to an applicant approved by the College of Pharmacy Committee.

8. Resolved that this Association adopt the endorsement of the Quality Stabilization Bill, with which you are all familiar.

9. Resolved that this Association adopt the resolution to bring our pharmacy laws up to date, eliminate those that are outmoded, and provide proper enforcement.

10. Resolved that this convention go on record as opposing the practice of certain manufacturers who make discriminating direct prices that make it unprofitable for a drug wholesaler to compete.

11. Resolved that this Association adopt the resolution that our public relations program be continued and expanded in the future.

12. Resolved that this Association furnish new application cards for renewal of the individual permits to practice pharmacy in the state of South Dakota to be reworded and in so doing omit the title "clerk" from the card.

13. Resolved that this Association congratulate the Rapid City Pharmaceutical Society in setting up a Drug Depot for Western South Dakota.

14. Resolved that the South Dakota Pharmaceutical Association accept the recommendation of the Executive Committee that this Association endorse and authorize the promulgation of legislative proposals for raising of permit and license fees set by law to provide for adequate inspection plus adequate per diem for Board of Pharmacy members.

15. Resolved that this Association urge all registered pharmacists to take a more active interest in politics.

REPORT OF THE NOMINATIONS COMMITTEE

James Rogers, Chairman
Pierre, South Dakota

The Nominations Committee wishes to submit the following names as candidates for the respective offices for the ensuing year:

President
Wayne Shanholtz ..... Mitchell
1st Vice President
Melvin Holm ..... Redfield
2nd Vice President
Nina Lund ..... Rapid City
3rd Vice President
Earle Crissman ..... Ipswich
4th Vice President
Lloyd Wagner ..... Marion
Treasurer
J. C. Shirley ..... Brookings

Members of this Association to be recommended

to the Governor for the Board of Pharmacy appointment which expires September 30, 1966:

Carveth Thompson ..... Faith
George Tibbs ..... Rapid City
Bernard Tennyson ..... Custer

The Nominations Committee consisted of Robert Ehrke, George Minard, Philip Case, Al Knutson and James Rogers.

REPORT OF THE TIME AND PLACE COMMITTEE

Clayton Scott, Chairman
Sioux Falls, South Dakota

Mr. President and Fellow Pharmacists:

The Time and Place Committee wishes to take this opportunity to thank the pharmacists of Pierre and to congratulate them for the wonderful time we have had. They stepped in and did a very fine job.

We have accepted the invitation from Mitchell for the 1964 convention, the invitation from Huron for the 1965 convention and have tendered our invitation to Watertown for the 1966 convention.

The committee consisted of A. Dean Shepersky, Huron; Robert F. Jones, Yankton; and Clayton P. Scott, Sioux Falls.

AWARDS PRESENTED AT THE 77TH SOUTH DAKOTA PHARMACEUTICAL ASSOCIATION CONVENTION

To Wayne Shanholtz:

McKesson and Robbins Gavel and Plaque on which is inscribed:

"Congratulations to the new president, Wayne C. Shanholtz, South Dakota State Pharmaceutical Association, 1963, extended by McKesson and Robbins. You have been chosen to wield this gavel. Let it be to you not only a symbol of your office, but a tribute to your success. Use its power, then, with purpose, with tact and with understanding."

To L. B. Urton:

E. R. Squibb and Sons President's Award:

Your South Dakota Pharmaceutical Association President has given a lot of time and a lot of energy to South Dakota pharmacy and to national pharmacy. In recognition, E. R. Squibb and Sons presents this President's Award to Mr. L. B. Urton with sincerest congratulations for a very good job.

To L. B. Urton:

Pepsodent Presidential Scholarship Award and Plaque. Inscribed on the Plaque:

"Awarded to L. B. Urton, President of the South Dakota State Pharmaceutical Association in recognition of his outstanding service and contributions to pharmacy."

To A. O. Bittner:

Plaque from the South Dakota Pharmaceutical Association on which is inscribed:

"The South Dakota Pharmaceutical Association extends congratulations, honor, and esteem to Albert O. Bittner for his loyal and faithful service to pharmacy while a member of the South Dakota Board of Pharmacy from October 1, 1959, to September 30, 1962."

Mr. Willis Hodson accepted for Mr. Bittner.

To T. C. Rutherford:

South Dakota Pharmaceutical Association Honorary President's Plaque.

To Harold W. Mills:

A. H. Robbins Company Bowl of Hygeia award.

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem.

KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



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Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

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AUTOMOBILES (AND NOW RABBITS) HAVE REPLACED HORSES

The effect of the economic motive can be detected in areas other than the obvious ones. Producing antipneumococcic serum from horses required many months and thus could not meet the demands of a changing market. Also this process was inefficient because the titer eventually achieved after many immunizations was not very high, and sometimes a horse would fail to produce serum of usable titer no matter how many times he had been immunized. Rabbits had been shown to produce antipneumococcic serums of high titer; they could be housed and handled more easily than horses; serum could be produced from them more quickly and thus the needs of the market could be followed more closely. Pharmaceutical manufacturers experimented with the production of commercial antipneumococcic serum from rabbits, found it feasible, and within a short time the production of antipneumococcic serum from horses was past history. — Harry F. Dowling, M.D. in **Archives of Internal Medicine,** Nov. 1962.

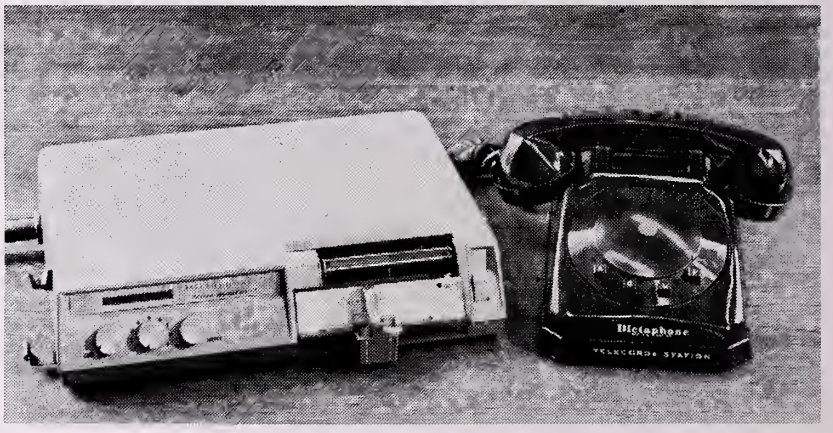
KEFAUVER RAISES DRUG COSTS?

I spoke with Mr. Kefauver on a program not long ago at the Waldorf-Astoria in New York. I talked about the great accomplishments of medicine and pharmacy here in the United States. Everybody seemed to be quite pleased. Then Mr. Kefauver was called on as the second speaker, and he said: "I would not contradict any of the statements that the doctor has just made but the cost of drugs is too high." How did he know that the cost of drugs was too high? If he had known why the costs of drugs were as high as they are, he would not have passed the law that has just passed, which is going to make the cost of drugs much higher than they have ever been in the past. No one can make the kind of tests that are demanded by the new legislation without adding appreciably to the cost of the drugs. — Morris Fishbein, M.D., at fourth annual New Jersey Pharmaceutical Industry Day, Union, N. J., Oct. 25, 1962.

NOT SO "SILENT SPRING"

Rachel Carson is a biologist of considerable stature. She has been a member of the zoological staff of the Marine Biological Lab-

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oratory at Woods Hole, has been employed by the Federal Bureau of Fisheries, and was for three years editor-in-chief of **Fish and Wildlife Science** magazine. Besides her master's degree from Johns Hopkins, she holds no less than four honorary doctorates, one in science and three in letters. Her qualifications as a biologist, and more specifically as an ecologist, and her skill as a writer are unquestioned. But there is some serious doubt whether she is well advised to exert her no mean talents to sow feelings of terror in the medical field, where her qualifications are somewhat more in doubt. — Editorial in **Rhode Island Medical Journal,** Oct. 1962.

"WHY DON'T THE CITIZENS DO SOMETHING?"

The citizen's reaction when confronted with such Chinese puzzles as the cost or control of drugs, atmospheric pollution, juvenile delinquency, and the laws concerning abortion, is to ask "Why don't the doctors do something?", even when few if any of these problems depend for their solution on the discovery or application of new scientific knowledge. Rather, these problems require new responses in social organization or adaptation; yet the public and some physicians continue to speak of them as "doctors' dilemmas" and "medical problems." — Editorial in **Canadian Medical Association Journal,** Jan. 19, 1963.

SHACKLES . . . HOBBLING . . . COLLECTIVISM

Our own American profession well can learn the lesson. . . . It is but little more important to maintain the freedom of the medical profession than to insist on the freedom of our hospitals from the shackles of government control, and the hobbling of the pharmaceutical industry by unduly restrictive legislation. In fact, all must be free or all will be subjected to collectivism. We should be as watchful for any significant signs of surrender to government pressures on the part of the American Hospital Association and the Pharmaceutical Manufacturers Association, as we are for the safety of our own freedom; and we should fight as hard for their freedom as we do for our own. — Editorial in **Nebraska State Medical Journal,** Jan. 1963.



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Insures stock and equipment against fire and extended coverage.



Protects assets against claims for injuries, claims for damage, medical expense, legal defense costs.



May include optional coverage on loss of business earnings, vandalism, burglary and robbery.



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EUGENE MURTAGH, PRESIDENT

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TO TEST . . . AND WHEN AND HOW TO TEST

Out of the wisdom of the Congress and the Food & Drug Administration, what are they ultimately going to consider substantial evidence that a drug does not have toxic side effects sufficient to warrant it from being kept off the market, or to decide what is substantial evidence of efficacy. We are going to have a merry time . . . We are going to have to determine just how many tests will have to be made on how many different kinds of animals, disregarding the human, before the drug will be considered safe. We all know that the ultimate test must be made on a pregnant mouse or a rabbit, or a rat, or a dog, or a chicken, or even a monkey, that will prove with certainty that that very drug might not have disastrous effects on some human being, her condition of pregnancy, if it is a woman, and many other factors. All of this is going to mean in the end a tremendous new burden placed upon the pharmaceutical industry. — Morris Fishbein, M.D., at fourth annual New Jersey Pharmaceutical Industry Day, Union, N. J., Oct. 25, 1962.

DRUG TESTING IS SORT OF LIKE SWIMMING

The testing of drugs for human use will always be a bit like a proposed swim in an inviting pool: though one may check the water for depth, temperature, pH, salinity, and even bacterial count, and though one may send out the family's pet chihuahua or macaque as a vanguard, one can never experience fully the feel of the water until one's own hesitating foot has been resolutely, unwaveringly, and irrevocably dipped beneath the surface. — Charles S. Sherwin, M.D., in **St. Louis Medicine,** August 31, 1962.

LEGISLATING AGAINST THE PATIENT

No one will deny that a strong Food and Drug Act is necessary to protect the public. But the intended (FDA) regulations will increase the cost of screening new drugs, will limit the number of new drugs approved, and may prevent many excellent medications from reaching the doctor. The . . . legislation will adversely affect the very person the law was meant to protect — the patient. — W. D. Paul, M.D., in **New Medical Materia,** Feb. 1963.

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1. Asher, L. M.: The Choice of Anticholinergic Drugs in the Treatment of Functional Digestive Diseases, Amer. J. Dig. Dis. 4:260-275 (April) 1959.

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References: 1. A.M.A. Council on Drugs J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

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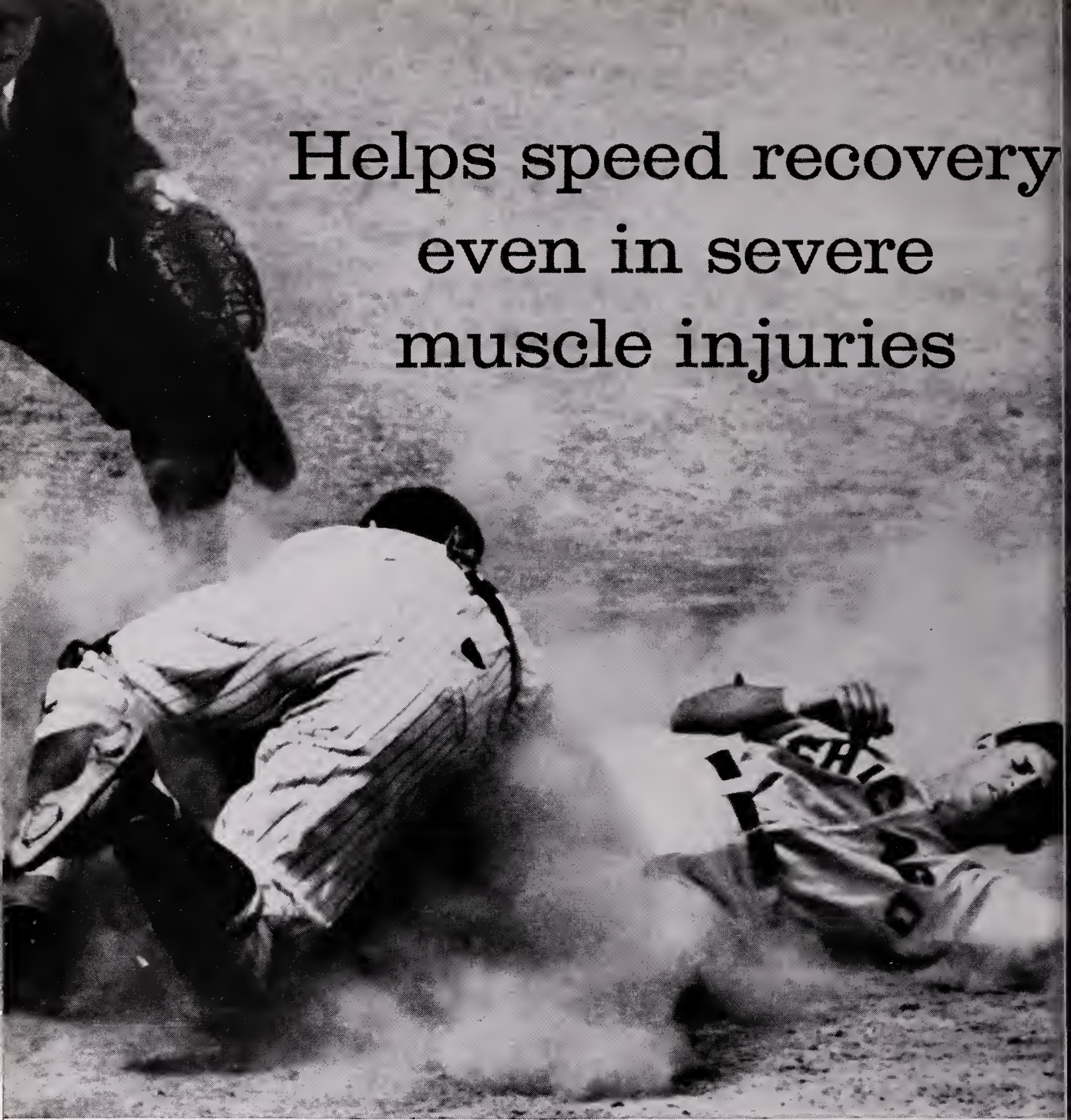
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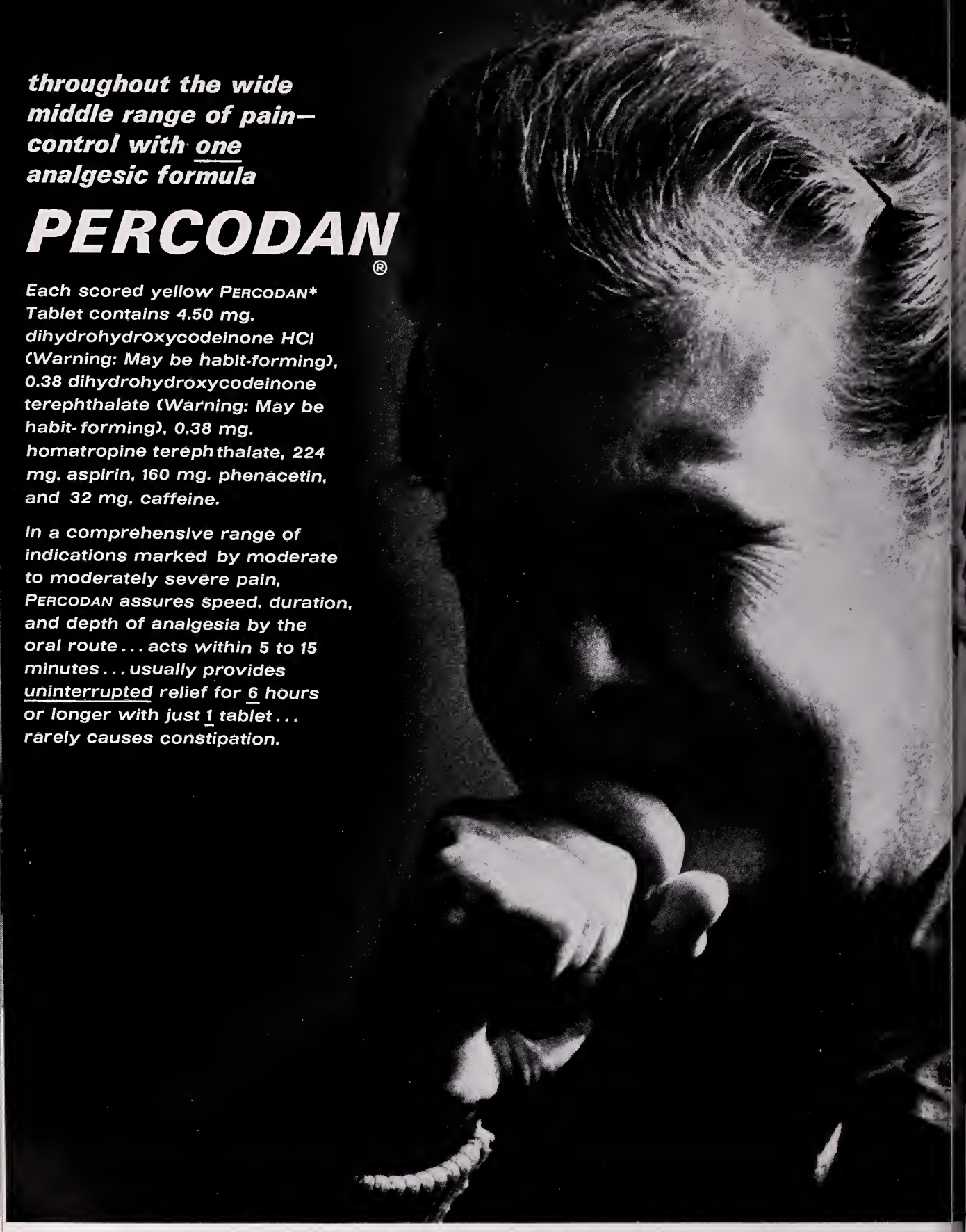
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Volume XVI **September, 1963** **Number 9**

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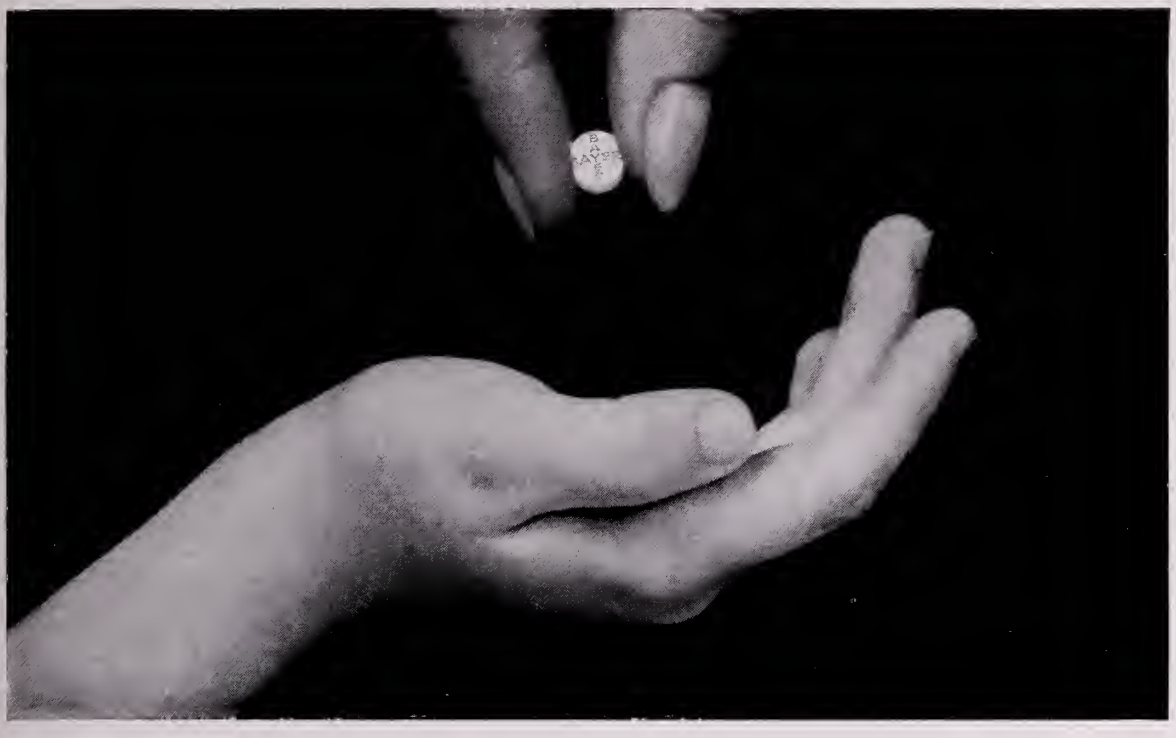
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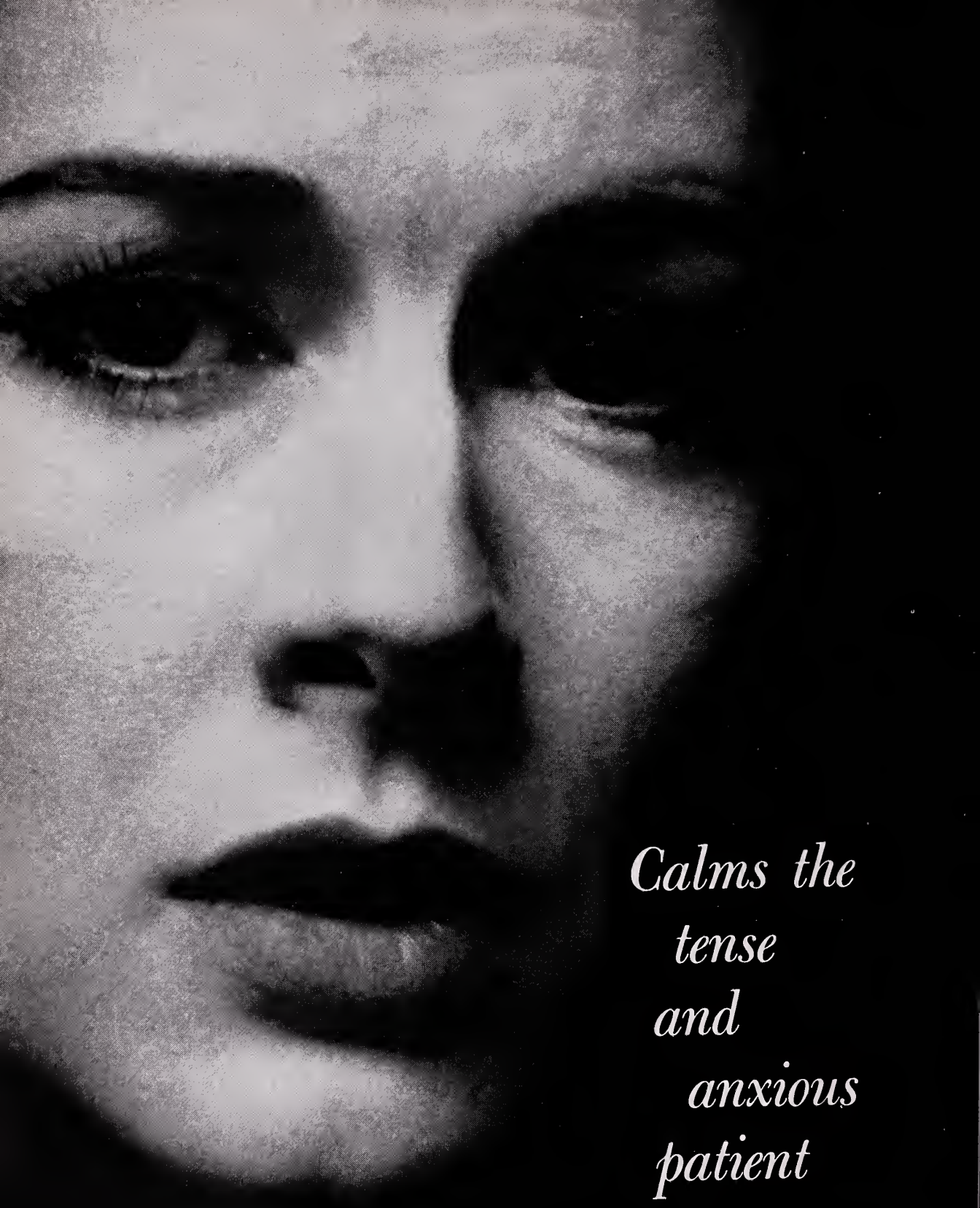
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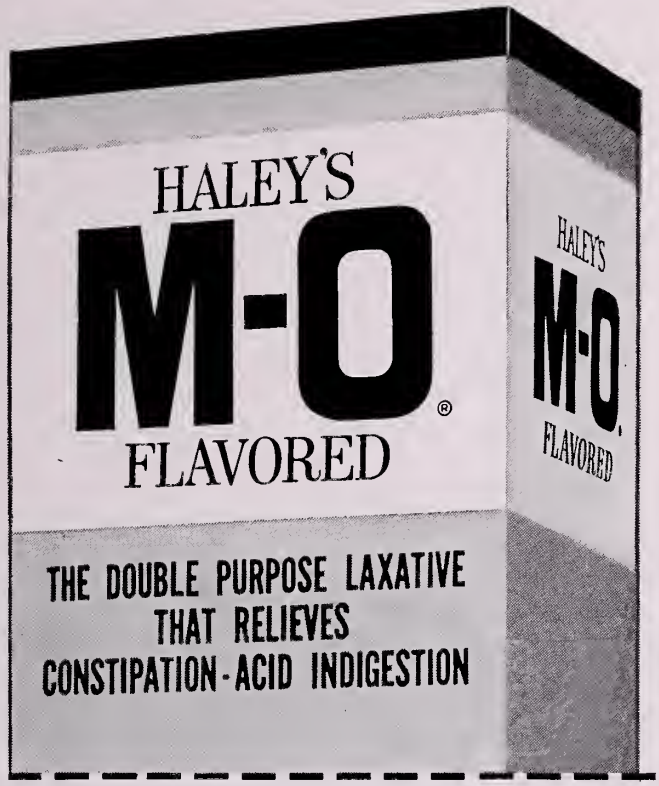


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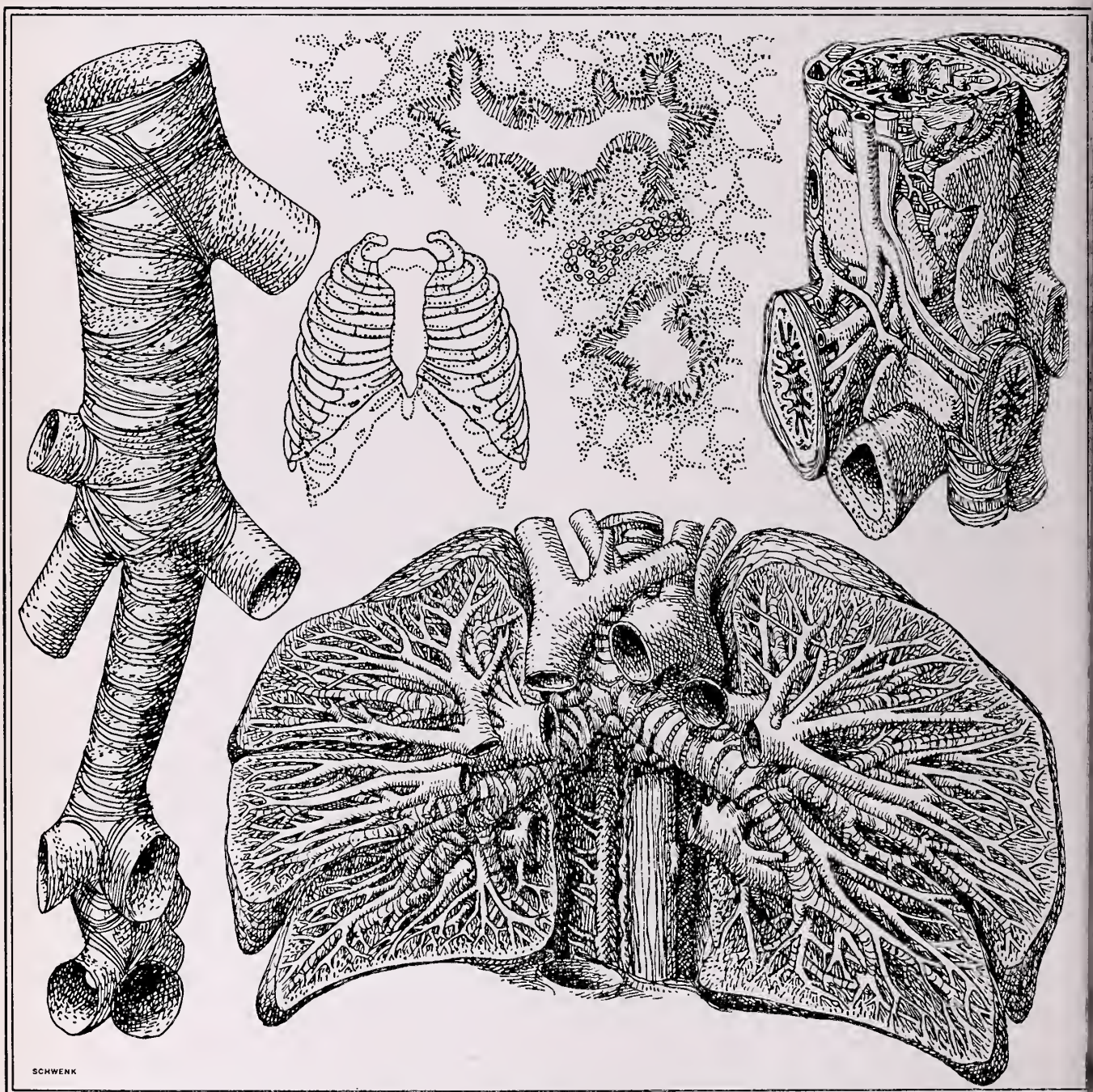
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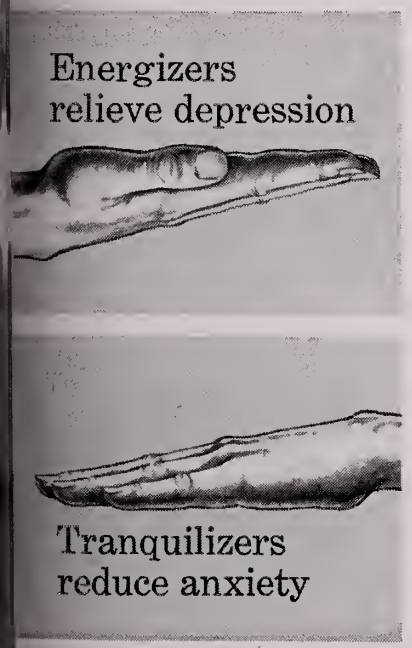
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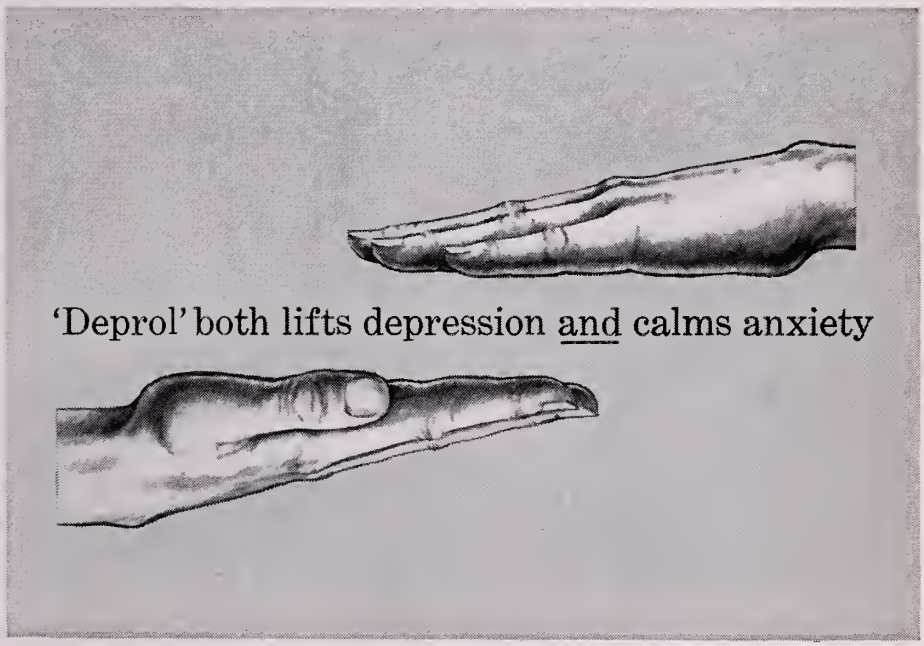
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OFFICE GYNECOLOGY 1963

Edwin J. DeCosta, M.D.
104 S. Michigan Ave.
Chicago 3, Ill.

Associate Professor of Obstetrics and Gynecology
Northwestern University Medical School

Statistically the most common ailment the gynecologist sees is vaginitis. Statistically the most common form of vaginitis or, more inclusively, vulvo-vaginitis, is that due to trichomonas. I have nothing new to offer in the treatment of vaginitis due to candida or that due to hemophilus vaginalis. The old standbys still occupy the number 1 positions.

With trichomonas it's different! Perhaps we should change the name, trichomonas vaginitis, to the French disease, because it was first described by a Frenchman, Donne,[1] in 1836, and it now seems that it will be cured by the discoveries of two Frenchmen, Cosar and Julou.[2] In the past, most discussions of trichomonas concluded that cure of even a reasonable percentage of patients was difficult. Actually I have never quite understood this attitude because I thought I was always able to cure most of my patients, but I too admit there were always some who resisted treatment.

To properly treat any illness we should know something about it, especially what it's due to and how it is spread. This information is very helpful in combatting the disease. In line with this, we must answer the question as to why the woman gets trichomonas in the first place. I am completely convinced that it is not from the G.I. tract, nor from the swimming pool nor the beach at Miami, except in rare instances. I am also completely convinced that in the vast majority of instances, it is spread by intercourse just like gonorrhea is spread by intercourse. In fact,

the two infections have been shown to frequently coexist.[3] It is most prevalent in women who are promiscuous or whose consorts are promiscuous, and it is exceedingly difficult to eradicate unless this bilateral aspect is considered. In the general population, trichomonas has been reported as occurring in from 10 to 45% of women. In my private practice, about 15% of my patients have trichomonas. On the other hand, in my service at Cook County Hospital, 70% of patients have trichomonas, and the vast majority of these are not even aware of any abnormal discharge. The discharge that they have, profuse and often odorous, is considered by them normal. The itch has either disappeared or, if still present, is considered a woman's lot and is ignored.

Since the male enters into this problem, it is interesting to note that in the general population, trichomonas in the male is estimated as occurring in from 4 to 8%, while trichomonas has been demonstrated in 60% of males whose lady friends are under treatment for vaginitis.[4]

Somehow many physicians just will not accept this venereal link. Whatever the reasons might be, let me assure them that it is well established and accepted, not only abroad[5] but in the United States as well.[6]

Today you can treat and cure trichomonas in a very short time by oral medication. Ideally the male should be treated at the same time. Since I am a gynecologist and do not treat males (although some of my friends have), I suggest, in fact I insist, that during my period of care, either complete abstinence be practiced or condoms be used. The interesting thing is that after about two months of this regimen, the organisms disappear from the male. The percentage of recurrence is relatively low, unless the male has been reinoculating himself elsewhere while you are treating his wife.

Metronidiazole (Flagyl, 8823 R.P.) has revolutionized the treatment of trichomonas. There have been other oral trichomonacides in the past that were useless, but this preparation will achieve a permanent cure rate of better than 90% with one week of therapy, unless the infection is reintroduced from the outside. There are few side effects, generally being confined to mild gastrointestinal upsets or an unpleasant taste in the mouth. I have had the opportunity of using Flagyl for the past year and consider it a wonder drug. My cure rate, as outlined, is 96%.

Unfortunately, you cannot buy Flagyl in the U. S., because the F.D.A. has not permitted its release. This apparently is due largely to a report of one investigator who described a drop in the leucocyte count. Incidentally, I have routinely run white counts on my patients, many more than in the series reported, and I have yet to see a significant drop in white count.

I am discussing Flagyl because I think in the relatively near future the F.D.A. will release this preparation and it will become available to you. Of the thousands of women who have used the drug, many during the time they were pregnant, there is not a single report of a serious side effect. That is more than we can say for aspirin. In the meantime foreign pharmacies are doing a good business in shipping the drug into this country. So for a bit longer, you may have to rely on the old standbys for trichomonas vaginalis vaginitis, but before long you will be in much better position to eradicate this scourge than you ever have been in the past. Remember, however, that the infection has been demonstrated in 60% of the male contacts and they may need treatment too.

Another phase of office practice that is and isn't office practice is the treatment of dysfunctional uterine bleeding. I say "is and isn't office practice" because very often we cannot make the diagnosis of dysfunctional uterine bleeding without having the benefit of dilatation and curettage or endometrial biopsy. I do not consider dilatation and curettage an office procedure, although some of my colleagues do. We might obtain adequate information on endometrial biopsy and this could be done in the office. However, I'm old fashioned enough to want all the information I can get and to still think that the dilatation and curettage has other advantages. It gives us more information because we have most all of the tissue for study. In addition, of itself it is often curative. Exceptions may be with the young girl in whom all other findings have been consistently

negative. We may be willing to treat her for a short time without adequate information about the endometrium.

Assuming then that we have concluded, with proof in most cases, that the abnormal bleeding is hormonal, I would be willing to prescribe one of the newer progestogens. I prefer the oral preparations to the parenteral. Oral preparations have the advantage of being rapidly metabolized and eliminated so we have some idea of what is going on. The parenteral, on the other hand, are often absorbed slowly and their effects may be prolonged. I use both norethindrone and norethynodrel, the latter always with mestranol — because that is the way it is marketed. I prescribe these medications much as I would prescribe them if they were to be used for oral contraception, cyclically for a period of 20 days and then a rest to permit withdrawal bleeding.

I can't give you scientific answers as to why the use of these substances is sometimes very rewarding, any more so than I can give you a good explanation for the factors that cause dysfunctional bleeding in the first place. Something obviously is at fault between the hypothalamus, pituitary, ovaries and uterus. Some of the factors are beyond present day scientific evaluation. When we use progestogens, we affect gonadotropic function, and in some way alter the balance between the various hormones. For want of a better term, someone once coined the expression "shaking the clock." Just as the clock which does not run, may occasionally "be cured" by shaking, so patients with hormonal dysfunctions may occasionally be benefited by the use of these preparations. Even though we still do not understand their action, the progestogens are the best available preparations for the treatment of dysfunctional uterine bleeding. Of course other factors like hypothyroidism have been investigated and treated before we conclude that dysfunctional bleeding exists. Not infrequently, infertility associated with menstrual abnormalities has also been cured.

And while we are on the subject of progestogens, another phase of office gynecology is the advice on birth control and the prescribing of suitable methods therefor. I am sure, whether you are interested in birth control or not, most of you have been consulted concerning the so-called pills, and many of you have prescribed the same. In some areas the pills are replacing the diaphragm, so, forgetting the moral, religious or philosophical outlook, we all need a basic understanding of what these substances do or do not do.

Like many of the naturally occurring hormones, the progestogens function by inhibiting gonadotropic secretion and thereby suppress ovulation. In addition, they are not too costly and are effective orally whereas the natural hormones generally are expensive and have to be taken parenterally. There are those who have coined the term "physiologic control of conception" in reference to these preparations. A much better term would be "biologic" or "hormonal" since there is nothing in the least physiological about the artificial suppression of ovulation.

Many steroid substances were investigated before it became apparent that the 19-nor compounds were the most desirable. Of these, two substances, norethindrone and norethynodrel, have been used extensively, but until recently only one, norethynodrel, has been available commercially. This is marketed as Enovid. The original tablet contained 9.85 mg. norethynodrel and 0.15 mg. mestranol, but the currently popular tablet now contains 5 mg. norethynodrel and .075 mg. mestranol. It is an effective contraceptive but suffers from the disadvantage of its side effects.

The side effects apparently are largely due to the induction of a pseudo-pregnant state. They are characterized by nausea, bloating, fullness of the breasts, increased weight, and at times cloasma. Not infrequently, abnormalities of bleeding also occur, such as inter menstrual flow while taking the tablets, or even amenorrhea after discontinuation.

Actually no one has ever produced evidence of detrimental effects to either the mother or to pregnancies which may subsequently occur, or even to the fetus in instances where the pills have been taken inadvertently during early pregnancy. While it is theoretically possible, no one has ever shown that there has been any long or short term effect on

ovarian or pituitary function. Certainly there is no evidence of changes in the endometrium or cervix resembling a malignancy.

The only problem with Enovid other than the nuisance of the side effects has been the concurrence of thrombo-embolic phenomena in women taking the preparation. As of this moment, there have been more than 272 reports of thrombophlebitis, with 31 instances of death due to embolism. This is a shocking figure but one must remember that over 3,000,000 prescriptions for tablets have been filled. Death from pulmonary embolus would thus occur at most once in 100,000 users. But what is the incidence of thrombo-embolic disease in an otherwise normal population? This is a difficult figure to ascertain, but it has been stated that thrombophlebitis may be encountered once in a thousand patients. I have seen thrombophlebitis in otherwise healthy non-pregnant women only once or twice in my life, but never pulmonary embolism. I would like to ask you in this audience how often you have observed either thrombophlebitis or pulmonary embolus in otherwise perfectly normal, healthy young women. Your collective experience probably exceeds half a million patients, but you have rarely encountered thromboembolic disease. Hence the report of 272 cases might be significant. Nevertheless, as of the present moment, following investigations made by the Searle Company, it has been concluded that there is no causal relationship between thrombophlebitis, pulmonary embolus, and the use of oral contraceptives. Only recently has anything come to my attention to indicate that oral contraceptives may be the cause of alterations in the coagulation mechanism. Egeberg and Owren[7] have observed a marked increase in the activity of the antihemophilic A factor (Factor VIII) and a slight increase in proconvertin (Factor VII) activity in patients who were taking Enovid. Their series was small and as of the moment has not been corroborated. As time goes on, the mechanism of clotting becomes more and more involved and what they observed may not be factors which caused thromboses, but it is another straw in the wind. I will leave it to you to decide whether this remotely possible risk is reason for abandoning the use of oral contraception.

As for me, my attitude is very simple. If the current method of birth control used by a patient is satisfactory, I can see no reason for changing. If it is unsatisfactory, if the frequency of intercourse is great, if the husband refuses to cooperate, or if the various mechanical procedures are emotionally undesirable, I do not hesitate to prescribe these preparations. However, I would play it cautiously, and would not advocate the use of oral contraceptives for women who have a history of previous embolic or thrombotic disease, or in those who have varicosities or a family history of thromboses.

Psychically great benefit may be derived from the use of a product which does not require advance preparation. In addition, increase in weight which some people experience, improved complexion, decrease in menstrual flow, and decrease in discomfort, all favor oral control of conception. But while we're on the subject of the psychic benefits, we must remember that an occasional patient seems to have adverse reactions. I have had several patients complain of becoming depressed, and even if the oral contraceptive was not responsible, nevertheless it was necessary to discontinue its use.

Before closing, I would like to say a word about that most important of office procedures, the Pap smear. In my lifetime of practice, this has probably been the single most important contribution to gynecology. I know that all of you appreciate its great worth and routinely take smears once a year on all your female patients. But I also know that you sometimes find the cytologist's report confusing.

There is no problem with Class I smears. They are normal. There isn't much problem with Class V smears. They indicate carcinoma. It now remains for us to determine the site of the cancer and whether it is invasive or not. We ascertain this by performing a dilatation and curettage and a cone, which are not office procedures.

Class II smears are of themselves no problem. They indicate inflammatory reaction. After proper treatment of the infection, the smear is repeated. Class IV smears also are not too perplexing. Our course is quite well outlined. We must determine the source of

the atypical, probably malignant cells. This can be done by biopsy in the office or, again, dilatation and curettage and cone in the hospital.

Class III smears are probably the most worrisome. Cells are atypical and suspicious but not of such a nature as to warrant a diagnosis of probable malignancy. If infection is present, particularly that due to trichomonas, we must clear it up. If the repeat smears are negative, there is no further problem. But if it is still atypical, the least we should do now is four-quadrant biopsy which can be done in the office. If this fails to disclose the probable origin and type of the unusual cells and if the smears continue to be atypical, I would recommend proceding as with Class IV or V. We have little to lose but much to gain.

Under no circumstances would we permit the smear to establish a definitive diagnosis. The smear is solely a report of the desquamated cells. To make the diagnosis of malignancy without study of the actual tissue is not good medicine. Certainly a major operative procedure, such as hysterectomy, is not to be undertaken just because the Pap smear is atypical. The choice of procedure must be based upon complete information and this means study of the tissue. With this information, radiation may be indicated rather than surgery. In the past, this careful approach has not always been followed. It is hoped that it will be in the future.

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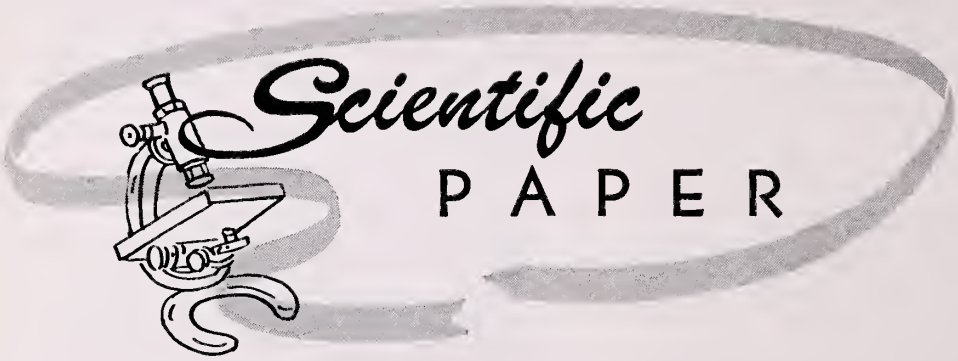
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"The Recognition and Management of the Emotionally Ill Office Patient"

Jackson A. Smith, M.D.*

These are tense times, but these are also times when it is fashionable to be tense. We are taught to be anxious, competitive and concerned. The only people who consider tranquility a virtue in children are the next door neighbors. In fact, it may be said that we have an epidemic of "lost tranquility"; since 10 million people have taken one of the many available tranquilizers, there must be an epidemic of some sort.

Tranquility may be defined as a state of calm, serene composure free from disturbance and unaccompanied by wakefulness; it is a state certainly to be desired in self but not so appealing in one's employees. Those who lack tranquility and are uncomfortable are usually anxious.

Anxiety is a condition in which the patient is uncomfortably aware of himself. He is morbidly apprehensive, he is in "a harmful state concerned with harm to come." He has an unreasonable fear of what may happen to him in the future. He is possessed by self doubt.

These are not times in which weeping and wailing and gnashing of teeth are well tolerated, so the patient makes a great effort to conceal his misery. Usually he has evidence of autonomic dysfunction, and he overresponds to all stimuli. Subjectively he experiences "ringing ears," "blurred vision," "dry mouth," and "lump in his throat."

* Clinical Director, Illinois State Psychiatric Institute, Chicago, Illinois

He is aware of his heart beat, and frequently has frightening cardiac palpitations which he assumes indicate a "heart attack." He is aware of his respiration and of his extremities which feel cold and numb, these symptoms he attributes to "poor circulation."

But, when he consults his physician, he is unlikely to describe the nature and extent of his discomfort; because he fears what the symptoms may "mean." Instead, he is more apt to merely say, he wants a "check up."

Anxiety may arise from within or from without. The internal causes are usually more enduring and relate to the patient's unsatisfactory patterns of behavior or living. For example, he may feel a need to please everybody. He may dislike arguments so much that others impose on him. The patient may not gain confidence from what he achieves, and he may constantly fear that he will fail.

Other anxious people seek arguments to avoid worrying about themselves. They may create situations which demand their attention or seek excessive work or obligations which are so consuming that the patient, literally, does not have time to worry about himself. Characteristically, those whose anxiety arises internally show lifelong patterns of these types of behavior.

Patients whose anxiety arises primarily from without are usually more briefly ill. They can date the time they last felt comfortable. The external causes of anxiety vary according to the patient's age and sex, but the following are frequent sources of conflict; the death of a peer and trouble at home or work.

It must be recalled that in the young the death or serious illness of a peer is unusual, but with increasing age it becomes commonplace. For example, the more of a man's friends who suffer coronary occlusion, the more aware of his own heart he becomes. The more frequently a woman's contemporaries develop cancer, the more alert she becomes to the possibility of a similar fate. But these are not pleasant topics to dwell upon and the patient avoids considering them. Too, he may have no conscious awareness of the relationship between his anxiety and his fears.

The practitioner should be aware of another mechanism the patient utilizes to escape fears of heart disease or cancer. He may settle for a lesser illness and therefore a lesser worry. For example, a patient's real fear may be of a "heart attack"; but he complains of gastrointestinal symptoms because he would prefer having an ulcer to the possibility of having a coronary occlusion. Similarly a woman may seek reassurance that she is not hypertensive although her real fear is of cancer. In either case disproving the lesser fear leaves the basic concern untouched and is doomed to failure.

Besides illness or death in a peer, there may be conflicts in the patient's marriage or work which he is unable to alter or correct. For example, the prospect of having to take an aging mother-in-law into the home may be an abiding source of worry to a wife; or a man may have a new supervisor who is demanding and inconsiderate, but he still has to work and earn a living whether he likes his employer or not. Unfortunately, in either of these cases the patient will not see the connection between his symptoms and these external problems.

The practitioner should explore all of these areas with the patient before resorting to a tranquilizer. On the other hand, when he finds the source of the patient's anxiety there is no need for an extended explanation as to how the conflict relates to the anxiety. All he needs to do is nod and let the patient do the talking.

Besides those who are anxious, there are patients who are forever weary with a fatigue which is unrelieved by rest. It should be recalled that 50 years ago we had an epidemic of "biliousness" in which at least 10 million tired people were walking about with "coated tongues and toneless livers." One should also recall that this group of patients were given one of the first energizers — calomel. Calomel quickened the stride and gave the patient a good "cleaning out" as well; and even if the first dose failed, the second was sure to energize. But the bilious are long since healed and their descendants are more often emotional than constipated.

Now, as to the newer drugs. . . . There are certain apparent hazards involved in the enthusiastic espousal of new treatments, par-

ticularly newer drugs. These hazards include the fact that the results may be due to the enthusiasm of the investigator rather than the action of the product; and, as a consequence, a less optimistic clinician may find the compound ineffective. This finding is neither rare nor alarming because with any class of new compounds one of two possibilities may occur, the practitioner becomes increasingly skeptical and ceases to prescribe them, or else a specific remedy is found which passes into the obscurity of routine use. In fact new drugs are like children, the first born creates the most turmoil; but after you have 10 or 12 that look alike, sound alike, and even act alike, most of the surprise is gone.

On the other hand there is a need for the constant efforts of clinical investigators, even if they err on the side of optimism, to prevent treatment's becoming stagnant and unchanging. The trial of new drugs or procedures is not without hazard. Because, by tradition and by statute the physician is supposed to treat according to the prevailing medical practice in his community. If these precepts had been closely adhered to, we would still be discussing the advantage of blood letting, a new breed of leech or the latest long acting purge.

In spite of the hazards to those administering and those receiving new drugs, it should be stressed that there were 3 times as many products added to the U. S. Pharmacopia between 1935 and 1955 as there were in the preceding two decades. But, in this same interval, the number of potent remedies increased many fold and the practice of medicine was greatly altered. The physician, as Farrar said, became much "less dependent upon faith and good hygiene, and the polypharmacy or 'shotgun' therapy." And during this interval the basic philosophy of treatment changed from "do no harm" to "do some good."

It is an unfortunate fact that a compound's potency to improve may be accompanied by a capacity to cause drastic and disturbing side effects. These side effects may be immediately apparent or they may be delayed. Very rarely they are extended to the next generation as in the tragic case of thalidomide. Consequently, their indications and contra-indications are more exact than many older remedies.

The newer drugs in psychiatry are primarily the tranquilizers, the skeletal muscle relaxants, and the energizers. The tranquilizers seem destined to survive and they have already prospered. But the energizers have shown a certain anergic hue during the past couple of years. The skeletal muscle relaxants as a group probably make up the most of the recently introduced compounds.

Using their most frequently reported action as a method of classification, these newer drugs may be grouped under the above mentioned headings of tranquilizers, skeletal muscle relaxants and energizers.

Before discussing these groups, one might first consider the number of different compounds in each. As an example, there are 33 tranquilizers available; these include 15 phenothiazine derivatives, 4 Rauwolfia alkaloids, and 14 skeletal muscle relaxants. All of these are compounds which in some degree tranquilize. I believe that a detailed individual description of each would have a greater sedative effect than any one of them taken orally.

In addition to the tranquilizers, in the past there were 17 energizers available, but 3 have been withdrawn from the market; and now, there are only 14 which makes my task more brief if no less confusing. We not only have newer drugs in psychiatry, we also have newer terms. In fact psychiatry is seldom bereft of hope, theory and new terms. Before 1955 depression was treated with CNS stimulants; after that date, the next group of drugs for this condition were called energizers; and now, they are all grouped together as antidepressives. It is not unusual for a new drug for depression to be introduced with the conclusion that it will replace electroconvulsive therapy. So far this has not happened, and it seems most unlikely that any of the presently available compounds will accomplish this end.

The surviving antidepressives include 4 compounds which cause monoamine oxidase inhibition. For those who share my limited chemical orientation, monoamine oxidase is an enzyme which is essential to the metabolism of serotonin. 3 of these inhibitors are

hydrazines and 1 is a nonhydrazine. The remainder of this group of antidepressives consists of 3 amphetamines and 7 other compounds of diverse structure. All of these drugs purportedly stimulate, energize or in some manner increase the energy output and improve the patient's mood.

This gives a grand total of 47 "newer drugs" which does not include the several trade names under which the same product may be beneficial. This should and does make for quite a few samples in the mail for the practitioner to be familiar with. The present situation is remindful of the barbiturates era which began in 1903, eventually over 2,500 barbiturates were synthesized and more than 50 were marketed. There is one difference in the two eras, the barbiturates were simply given by physicians and they either sedated the patient or they didn't; but now, we have research institutes, statisticians and Congress trying to decide the same thing.

Mode of Action of the Newer Drugs

The potent tranquilizers: This is dangerous ground which is best trod by sticking to generalities. The tranquilizers (phenothiazines and rauwolfia alkaloids) tend to reduce the patient's response to internal and external stimuli, they decrease concern without producing euphoria or increasing self confidence, — which prevents their ever becoming a threat to the beverage industry.

The tranquilizers have been on the market for more than 8 years and have been given to several million people in this country alone — but oddly enough there is still some discord as to the most desirable dosage, how long they should be given and how specific they are.

There are 2 or 3 apparent reasons for this discord; first the tranquilizers have such a variety of actions. Besides quieting the disturbed, they cause the virtuous to lactate, produce Parkinsonism in the young and occasionally cause seizures. Unlike the sedatives, these compounds do not cause ataxia (although the patient may literally fall down in a hypotensive faint, they do not produce anaesthesia, excitement or any pronounced tendency to addiction. They also differ from sedatives in that they increase muscle tone and lower the seizure threshold.

The second reason for discord regarding these compounds is that their actions are not immediate, like pregnancy there may be quite an interval between administration and effect, and if several are given it is difficult to say which one caused the trouble.

The "mild" tranquilizers: The group of compounds variously referred to as skeletal muscle relaxants or "mild tranquilizers" have little in common except the fact they are recommended for the relief of anxiety. The non-specific nature of the actions of some of these relaxing compounds is best shown by the following: two of the members of this group, benactyzine and meprobamate (alias Equanil and Miltown), when taken at the same time, do not become a more potent tranquilizer — instead they become Deprol, an energizer! This is indeed a wonder drug, or at least enough to make one wonder, since the results are comparable to giving a bromide and a barbiturate to wake a patient up!

The anti-depressives: In the first place the treatment for depression whether by psychotherapy or by drugs, is advocated as though depression were a "thing" i.e. a distinct entity; but at a recent symposium of this affliction, 13 types of depression were listed and 5 more were recommended. When there are 14 drugs recommended for 13 possible varieties of depression, some contradictions in treatment results could occur — and have.

The monoamine oxidase inhibitors, called energizers, were first advocated because they brought about an accumulation of serotonin by interfering with its destruction. It was presumed desirable for serotonin to accumulate because a known hallucinogenic agent, LSD, was a powerful antagonist of serotonin. In addition reserpine, a tranquilizer, caused serotonin to accumulate. Of course, it should be noted that although one of the compounds tranquilized and the other energized, they both caused an increase in serotonin — but this was a minor paradox which no one seemed to mind.

As time went by, a clinically effective energizer, imipramine (Tofranil), was marketed even though it had no appreciable effect on serotonin metabolism. At this point, the term energizer began to give way to the more general name antidepressive. Presently, the im-

portance of monoamine oxidase inhibition is less often emphasized.

Clinical Differences: There are certain categorical similarities between the 3 groups of newer drugs, for example — they all act to relieve symptoms, and they do not alter causes. Too, the greatest variations in the members of the different groups, whether they be tranquilizers, skeletal muscle relaxants or antidepressives, are in their potency and the nature and the severity of the side effects they produce.

The differences in the 15 available phenothiazine derivatives are more evident in their chemical structure and in their effects on animals than clinically. For instance, the fact that one phenothiazine is more effective in lowering the body temperature in rats than another or antagonizes the "waltzing syndrome" in mice to a greater degree, may really stimulate a pharmacologist while leaving a clinician with controlled enthusiasm. On the other hand, reports that one phenothiazine causes less Parkinsonism, jaundice and photosensitivity than another is meaningful to the practitioner in prescribing these compounds.

However, if a patient fails to respond to one potent phenothiazine, it is unlikely that he would benefit from another similar acting compound with a different name. The evidence for specificity among these drugs is scanty. The differences, clinically, in the rauwolfia alkaloids are also minor. Among the potent phenothiazines, chlorpromazine (Thorazine) and thioridazine (Mellaril) continue to be favorably reported. Chlordiazepoxide (Librium) is a newer mild tranquilizer that has been enthusiastically received.

Among the antidepressives amitriptyline (Elavil), tranylcypromazine (Parnate) and imipramine (Tofranil) have few reported serious side effects which is encouraging. The anti-depressives which are hydrazines (Marplan, Niamid and Nardil) are contraindicated in patients with a history of liver disease. A severe toxic hepatitis may occur in patients receiving hydrazines; and the liver function, in those for whom these compounds are prescribed, should be closely observed.

One of the more encouraging aspects of these newer compounds, only 3 of which were in existence 10 years ago, is the continuing search for products with greater potency and fewer side effects. Even if there were a hundred similar compounds on the market the need for specific treatment would certainly be no less. It is not mere chance that the most effective treatments in psychiatry have been for illness of known etiology. When the relationships between the spirochete and paresis and between nicotinic acid and pellagra were established, the problems these afflictions presented were in the process of becoming answerable. Nevertheless, it is essential that the search for new compounds continues during the interval of our etiological ignorance.

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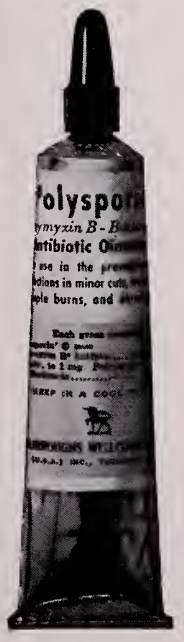
MEDICAL SCIENTIFIC EXHIBITS

At the recent meeting of the State Medical Society in Yankton there was an innovation, the large number of scientific exhibits put on and sponsored by individual physicians and medical groups from the state. Those who attended the meetings had the opportunity to see displays on medical subjects ranging from Trisomy problems to heart disease. The interest in scientific exhibits is a good trend and it is to be hoped that similar projects may play an increasing role in future state medical meetings.

In previous years it was unusual for there to be greater than four or five scientific displays. In 1963 there were sixteen excellent scientific exhibitions. Booths presented by drug houses, insurance firms and others have usually totaled from thirty to forty five. In 1963 there were thirty four commercial exhibits. Commercial displays are important and informative, playing a helpful role in the detailing of new medications, medical supplies and services. The commercial displays are important to the State Medical Society in that they help defray the cost of at least a part of the annual meeting. The scientific displays do not produce revenue to the state society in monitary units but their potential value for education and dissemination of ideas is tremendous. They allow the members of the Society who may not have the opportunity themselves to indulge in original investigations to see what is being done elsewhere in the state.

The annual meeting is to be held in Sioux Falls in 1964. Now is the time for plans to be made for possible scientific displays at that time. If it is the concensus of the members of the State Society that these displays are of sufficient educational value, it would be helpful to the planners of the coming state meeting to know these sentiments, so that arrangements for adequate space for exhibits can be made. It is possible that the meeting could be held in the Sioux Falls Coliseum, in which building there is sufficient room for many scientific and commercial displays. Undoubtedly members of the state society will be canvassed in the near future by the meeting organization committee in order to find those who desire to present scientific displays in 1964. Early planning of exhibits is to be encouraged. Comments from the members of the Society regarding their thoughts relating to the use of these exhibitions would be helpful and would be appreciated by the program preparation committee. J. B. Gregg, M.D.

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The following program will be presented at the 4th Annual Regional Meeting of the American College of Physicians to be held Saturday, September 28, 1963. The meeting will be held in the Medical Science Building on the Campus of the Univ. of South Dakota in Vermillion.

Place: Medical Science Building
University of South Dakota
Vermillion, S. Dak.

Date: Saturday, September 28, 1963

Proposed Scientific Program, morning session:		**Presiding:** D. L. Kegaries, M.D., FACP Governor, ACP for South Dakota
8:30 a.m.	Paper ..... case report (title and subject to be announced)	R. Bareis, M.D. (Associate) Rapid City, S. Dak.
8:45 a.m. to 9:45 a.m.	Coronary atherosclerosis, recent advances in the study of cause and treatment	Wm. C. Connor, M.D. Iowa City, Iowa
9:30 a.m. to 10:15 a.m.	Congestive heart failure, basic causative mechanisms, recent advances in therapy	John W. Eckstein, M.D. Iowa City, Iowa
10:15 a.m. to 10:30 a.m.	Recess — Coffee break	
10:30 a.m. to 11:15 a.m.	Hypertension, recent advances in the causes and treatment of	Walter M. Kirkendall, M.D. Iowa City, Iowa
11:15 a.m. to 12 noon	Panel (Symposium)	Drs. Kirkendall Connor Eckstein
12 noon	Luncheon — Buffet Style Courtesy of University of South Dakota	
1:10 p.m. to 2:00 p.m.	Meeting of University of South Dakota Preceptor-Physicians	**Presiding:** W. Hard, Ph.D., Dean School of Medicine U.S.D.
Afternoon Scientific Session		**Presiding:** J. Calene, M.D., FACP Aberdeen, South Dakota Former ACP Governor for South Dakota
2:00 p.m. to 2:15 p.m.	Paper ..... case report (subject to be announced)	D. L. Kegaries, M.D., FACP Rapid City, South Dakota
2:15 p.m. to 3:15 p.m.	Rehabilitation and return to work after a myocardial infarction. (Evaluation of the individual patient's ability to work. Work load tolerances.)	C. P. Kolars, M.D. Cardiac Work Evaluation Unit University of Minnesota Minneapolis, Minn.
3:15 p.m. to 3:30 p.m.	Recess — Coffee Break	
3:30 p.m. to 4:30 p.m.	Panel — (Symposium) Return of the cardiac to useful employment.	Drs. Kirkendall Kolars Eckstein Connor
4:30 p.m. to 5:30 p.m.	Annual Business Meeting — South Dakota Society of Internal Medicine	
6:30 p.m. to 7:00 p.m.	Social Hour **(The Prairie)**	
7:00 p.m.	Annual Banquet **(The Prairie)** (Registrants, guests, speakers, medical students, and medical school faculty invited.)	**Toastmaster:** W. Taylor, M.D., (Assoc.) President, SD-SIM **Speaker:** Ed C. Rosenow, M.D., FACP Executive Director American College of Physicians

PRESIDENT'S PAGE



Dear Fellow Members:

In the June issue of our **South Dakota Journal of Medicine and Pharmacy,** I am sure you all noted with a great deal of interest the paper presented by Dr. Theissen of Rapid City, concerning the use of routine Papanicoloau smear for detection of early pelvic malignancy.

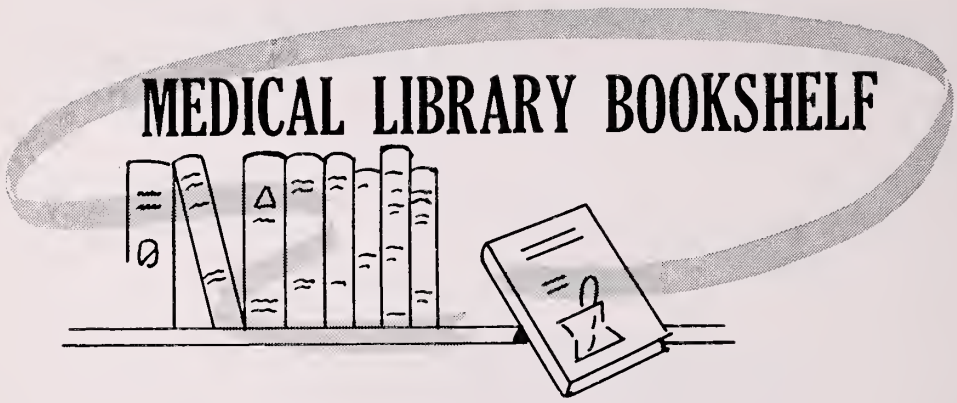
This should be of interest to us for two reasons. The first is that this is an easy office procedure of value to the physician in making the diagnosis and also of tremendous value to the patient in knowing that the physician is utilizing a procedure which she has read about in **The Ladies' Home Journal, Saturday Evening Post,** etc. The comments which people make about having had the test performed certainly are varied and interesting. I am sure that I would not be adding to your knowledge by repeating many of those that I have heard. It does point out one thing, and that is, that this is a procedure that the patient is willing to have done and I suspect she finds it strange if it is not done.

The second point is that Dr. Theissen presented a paper which most of us, I feel, find to be of value because this deals with the procedure well known to all of us and yet is taken from our own back yard. It actually deals with results in South Dakota — not the University of Illinois or the Mayo Clinic. I am sure that each of you, like Dr. Theissen, has something to offer all the rest of us, and these are the papers that we all want to read. The plea is for each of you to write for our Journal that in which you are interested. Because you are interested it will also be of interest to all of us. Interesting case summaries or studies exist in each of your practices, and I feel certain that all of you could take the time somehow to get this to our Journal Editor.

Dr. Theissen's paper brings forth the latter idea, and I wish to compliment him and all of those of you who write for our Journal. I wish to urge all of you to take time to do the same.

Sincerely,

Robert H. Hayes, M.D.
President



SECOND INTERNATIONAL CONGRESS OF MEDICAL LIBRARIANS

The Second International Congress on Medical Librarianship was held at the "plush" Shoreham Hotel in Washington, D. C. the week of June 16-22, with the U. S. Medical Library Association as host.

More than a thousand librarians from 60 countries were registered with the most coming from Canada, Great Britain and South America. There was a delegate from Ghana; Arabia; New Zealand; the Canal Zone; Iran; Lebanon, and Malaya. Several iron curtain countries were represented including Yugoslavia, Poland and Hungary.

On Sunday evening the Congress heard Mr. William Le Fanu, Librarian of the Royal College of Surgeons of London, England who had been the chairman of the First International Congress held there in 1953.

One special service to the members of the Congress was the simultaneous translations in English, French, German and Spanish with earphones and batteries issued to those desiring them.

One of the foreign speakers was Dr. Andre Hahn, Conservateur en Chef de la Bibliotheque de la Faculte de Medicine, Paris. His topic was "Education and Training for Medical Librarianship." Dr. Hahn and Paul Dumaitre have recently published a book with the lengthy title "The Histoire de la Medicine et du Livre Medical a la Lumiere des Collections de la Bibliotheque de la Faculte de Medicine de Paris," Olivier Perrin, 1962. 430 p.

According to the review of this book found in The Bulletin of the Medical Library Association v. 51, April 1963, p. 306, the central library of the Faculty of Medicine of Paris has a vast abundance of journals and books both ancient and modern which enabled these two authors to produce a comprehensive history of medicine and the medical book.

The first chapter provides a history of the Faculty's library from the origins in 1732 to the present with 5 subsequent chapters devoted to the 15, 16, 17, 18 and 19th centuries, including the history of medicine, the book and medical books in the Faculty's library. A concluding chapter is on the bookplates of the Faculty of Medicine and the Academy of Surgery.

The chairman for the Friday session which was on Interlibrary Cooperation was Mr. Samuel O. Falayi, Librarian of the Central Medical Library of Yaba, Nigeria. He was resplendent in his colorful native costume; a long robe of purple material with a hat of purple and gold. Mr. Falayi spoke perfect English.

Because Mr. A. Morozov, Assistant Librarian of the State Central Medical Library of Moscow didn't arrive, his paper on Medical Libraries of the Soviet Union was read by

Mr. Alexsandr N. Izvekov, Third Secretary of the Embassy of the USSR.

The Marcia C. Noyes award, which is given for distinguished service in medical librarianship was presented to Dr. Stanislaw Konopka, Director of the Central Medical Library of Warsaw, Poland for his untiring efforts in establishing medical libraries and promoting medical librarianship in that country. Appreciation of his moving speech of thanks was shown by a standing ovation of those assembled.

The American Medical Association was host to the entire Congress at a reception held in the new South Hall of Georgetown University where a number of their medical staff were in the receiving line.

One of the highlights of the Congress, long to be remembered by all present, was the assembling on the beautiful south lawn of the White House where President Kennedy addressed the group and where Adlai Stevenson, who made an unscheduled appearance, was pressed into making a few extemporaneous remarks. Caroline and friends watched the proceedings from the upstairs window.

Mrs. Esther Howard
Medical Librarian

R. R. FISK, M.D.
1887-1963

Another South Dakota physician has made the journey to the "Beautiful Isle of Somehere." Dr. R. R. Fisk, well known Moody County practitioner, passed away June 29th in a Dell Rapids Hospital.

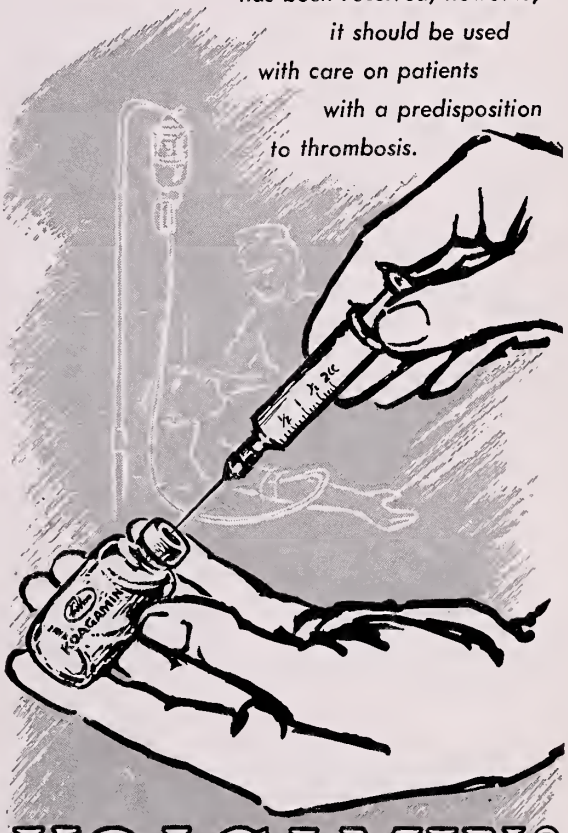
Dr. Fisk was born at Plainview, Minnesota, on June 11, 1887. He attended Medical School at the University of Illinois in Chicago and following two years of internship at Augustana Hospital in Chicago, he moved to Brookings where he began medical practice.

Following his discharge from military service in 1919, he moved to Flandreau where he practiced until his retirement a few months ago.

He is survived by two sons, Dr. R. G. Fisk, Dell Rapids and Dr. Quentin G. Fisk of Seattle, Washington.

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®
parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

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AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Office of the Executive Secretary
Robert L. Faulkner, M.D.
2105 Adelbert Road
Cleveland 6, Ohio

The next sheduled Part I (written) Examination of this Board will be held at various examining centers in the United States, Canada, and military bases outside of the continental United States on Friday, December 13, 1963, at 2:00 P.M. Candidates eligible to take this examination will be notified on or about November the first where to appear for examination.

SPECIAL NOTICE

PART I EXAMINATION (written), commencing in 1965, will be conducted in July at designated centers in the United States and Canada. Requirements, application, procedure, fees, etc., will be published in the 1964 Bulletin.

Candidates whose residency will be completed on or before June 30, 1965 will be eligible to make application to take the examination in July, 1965.

The 1963 Bulletin of this Board is now available and prospective applicants are urged to request this brochure and thoroughly familiarize themselves with the current rules and regulations before making application. Bulletins may be obtained by writing to — Robert L. Faulkner, M.D., Executive Secretary and Treasurer, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

Diplomates of this Board are requested to inform the Secretary's office of any change in address.

WARNING!!

A Federal Court has barred further distribution of four expensive but worthless medical devices and a fifth machine promoted by false claims, the Food and Drug Administration has announced.

The Agency said the injunction prohibits interstate commercial distribution of machines known as "Electronic Magnetic Model G," "Radioclast Model 40," "Auto-Electronic Radioclast Model 20, Series 800," and the "Electronic Analysis Instrument Model F." False claims for a fifth machine, the "Electro Sine Galvanic Model 200," were also prohibited.

The devices, which were sold to licensed and fringe health practitioners for up to $1,200 apiece, were promoted by alleged scientific reports written in pseudo-medical terminology and distributed through the International Electronics Research Society. Their danger to health, FDA said, is not what they do but rather what they do not do.

RESULTS OF A QUESTIONNAIRE ON THE EFFECTIVENESS OF PHARMACEUTICAL ADVERTISING CONDUCTED BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Total questionnaires mailed: 460

Total responses received: 322 — A 70% return

In answer to the question "Do you open your own mail?" 248 or 77.2% indicated that they did. 73 or 22.8% indicated they did not.

In reply to the question "Does all direct mail advertising reach your desk?" 243 or 76.6% indicated that it did. 74 or 23.4% indicated that it did not.

To the question, "If 'No', does **some** direct mail reach your desk," 60 or 81% indicated that some did; 14 or 19% indicated that none did.

To the question, "Do you read or scan the SOUTH DAKOTA JOURNAL OF MEDICINE each month?", 306 or 95.6% indicated that they did. 14 or 4.4% indicated that they did not.

To the question, "Do you read the advertising pages in the Journal?", 255 or 79.67% indicated that they did some of the time. 31 or 9.66% indicated that they always did. 34 or 10.67% indicated that they never did.

To the question, "Do you spend some time with pharmaceutical or surgical supply detail personnel?", 296 or 92.8% indicated they did; 23 or 7.2% indicated they did not.

To the question, "Do you visit the exhibits when you attend a State or National medical meeting?", 308 or 97.7% indicated "yes", 7 or 2.3% indicated "no."

The eighth question in the questionnaire asked the doctors to number the advertising methods in the order of their effectiveness in

bringing the advertiser's message to their attention. The eight listed were as follows: Medical exhibits at annual meetings; Direct mail to your office; SOUTH DAKOTA JOURNAL OF MEDICINE AND PHARMACY; The detail man; Your specialty journal; AMA Journal; The advertising gimmick (paper weights, ball point pens, key chains, etc.); and Sponsorship of medical seminars.

In determining the most effective method, the answers were grouped as to how many estimated that this method was first in effectiveness, second, and on down through the eight. Some of the respondents indicated that perhaps two methods were of equal importance and in tabulating, they were both given a number one answer. Totalling those that received votes for the first four places, it would indicate that the eight can be listed as follows as to effectiveness as far as the physician in South Dakota is concerned.

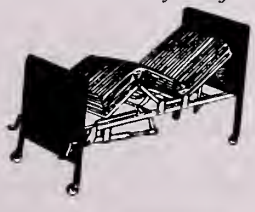
No. 1. The detail man
No. 2. Medical exhibits
No. 3. SOUTH DAKOTA JOURNAL OF MEDICINE AND PHARMACY
No. 4. The specialty journals
No. 5. Direct mail
No. 6. The AMA Journal
No. 7. Sponsorship of medical seminars
No. 8. The advertising gimmick

From comments received, which were unsolicited, on the questionnaires, it would indicate that those who felt that direct mail was not a proper method of presenting the advertising were most vehement that it was obnoxious to them to receive so much "throw away" mail. However, the actual tabulation did not indicate that this was the least effective, by any means.



Out Patient Needs
ELMEN
Rent-alls, Inc.
1701 West 12th
Sioux Falls, South Dakota
"We Rent Most Everything"

Everest & Jennings Wheel Chairs
Hospital Beds
Crutches
Walkers
Commodes
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Trapeze Bars



100's of Invalid needs
PHONE
336-3670

DKM INSURANCE

ONE POLICY REPLACES MANY!

NEW
DRUGGISTS MUTUAL MULTI-PERIL POLICY!

THE MULTI-PERIL *policy, for the first time, covers both fire and liability protection in one policy.*



Insures stock and equipment against fire and extended coverage.



Protects assets against claims for injuries, claims for damage, medical expense, legal defense costs.



May include optional coverage on loss of business earnings, vandalism, burglary and robbery.



This policy can also insure your buildings, glass, electrical signs, and many other coverages individually suited to particular needs.

ONE POLICY
PREMIUM
ANNIVERSARY DATE
COMPANY

AND AT A SUBSTANTIAL SAVING!

SEE YOUR DRUGGIST MUTUAL FIELDMAN — OR WRITE

DKM
Druggists Mutual Insurance Co.
EUGENE MURTAGH, PRESIDENT
HOME OFFICE — ALGONA, IOWA

This is your

MEDICAL ASSOCIATION

NEWS • NOTES • • • BIRTHS • • • CHANGES • NEWS

ANNUAL MEETING HIGHLIGHTS

Yankton meeting attracted excellent attendance — far above totals that were established last time there.

* * *

Outstanding program drew many, as did top-flight entertainment.

* * *

Dr. Donald J. Peik of Sioux Falls won trip for two to Las Vegas as grand attendance prize.

* * *

Speakers had a good time, too. Letters from many of the guest speakers indicated this was the best meeting they had ever attended.

* * *

New president, **Robert Hayes, M.D.,** was sworn in by House Speaker, **C. J. McDonald, M.D.** Dr. McDonald was sworn in as president in 1961 by Dr. Hayes, who was then Speaker. Expected horseplay didn't materialize.

* * *

Banquet turnout was biggest ever — and quite a jolt for the Executive Secretary, who is still searching for chairs on which to seat everyone.

* * *

Next year's meeting was awarded to Sioux Falls — replaced Watertown — because of housing situation. **Dr. Kendall Burns** is program chairman.

* * *

Physicians have better constitutions than some of the detail men. Two of our good friends ended up in the hospital during the meeting. All of our doctors made it.

* * *

As Caroline Richter said, the whole affair was "frustrate"—meaning "top-flight."

B. F. Lenz, M.D., Huron, attended an EKG interpretation at Mayo Clinic from May 18th to the 25th.

* * *

E. C. Hanisch, M.D., Huron, attended the American College of Obstetrics and Gynecology April 22-24th.

* * *

Attending the American Radium Society meeting in San Francisco, April 1st to the 4th was **G. Huet, M.D.,** of Huron.

* * *

Dr. W. F. Bollinger, Parkston, has retired from practice and is now living in Alexandria, Minnesota.

* * *

Dr. T. F. O'Toole, longtime Rapid City practitioner, retired on July 2. His practice has been taken over by **Drs. Arthur J. Barrett** and **Wenzel J. Kovarik.**

C. F. Binder, M.D., Chamberlain, was named president of the South Dakota Chapter of the American Academy of General Practice during the Yankton meeting in June.

* * *

Two interesting meetings were held by the Black Hills District Medical Society. The first was at Ft. Meade on April 9, 1963, at which time Dr. Edward M. Litin of Mayo Clinic discussed "Management of Difficult Patient." On May 23, Dr. Vincent Ferginin of the University of Colorado Medical Center discussed "Current Status of Measles Immunization."

* * *

Robert E. Van Demark, M.D., Sioux Falls, addressed the June meeting of the Third District Medical Society held at Madison, S. D., on the subject of "Hand Injuries."

* * *

On June 19th, Year Book Medical Publishers, Incorporated was advised by Luther H. Hodges, Secretary of Commerce, that it had been awarded the President's "E" for excellence in export.

* * *

Warren Lee Weeldreyer of Sioux Falls has been appointed a medical service representative by J. B. Roerig and Company, a pharmaceutical division of Chas. Pfizer & Co., Inc.

* * *

Dr. G. Howe, formerly with the Homestake Mine Hospital Staff in Lead, has associated himself with **Dr. J. C. Smiley** in Deadwood.

Dr. Raymond J. DesRosiers, formerly with the U.S.P.H.S. in Eagle Butte, has entered practice in Sturgis with **Dr. Joseph Hamm.**

* * *

Dr. Bruno Strauss, Parker, has closed his practice there to take a position at the University of Washington in Seattle.

* * *

L. L. Massa, D. O., Sturgis, was re-appointed to the State Board of Medical and Osteopathic Examiners for a five year term by Governor Gubbrud. Dr. Massa is the lone osteopathic member of the licensing board.

* * *

Dr. Clark Johnson, Yankton, has been appointed to the State Medical Panel on Industrial Diseases by Governor Archie Gubbrud. Dr. Johnson replaces **W. A. Arneson, M.D.,** of Sioux Falls.

* * *

Five physicians have been assigned by the U. S. Public Health Service to the Pine Ridge Indian Hospital. They are **James L. Taylor, M.D.; John E. Rittman, M.D.; John Truska, M.D.; Joseph Abadie, Jr., M.D.;** and **Robert R. Schwaegler, M.D.**

* * *

Lloyd C. Vogelgesang, M.D. has joined **D. R. Studenberg, M.D.** in Gregory, S. D. Dr. Vogelgesang has recently finished a post graduate course in Anesthesiology at Fairfield, Alabama. He practiced medicine for nearly a year in Kadoka, prior to serving in the U. S. Air Force.

* * *

Richard A. Kovarik, M.D. of Rapid City has been certified by the American Board of Obstetrics and Gynecology.

* * *

The 1963 Scientific Session of the American Cancer Society will be held at the Biltmore Hotel in New York City, October 21-22, 1963. The symposium on "Unusual Forms and Aspects of Cancer in Man," is open to all members of the medical and dental professions and students. For further information, write: Director of Professional Education, American Cancer Society, 521 West 57th St., New York 19, N. Y.

* * *

November 22-25 at the Palmer House in Chicago are the dates and place of the 1963 annual convention of the National Society for Crippled Children and Adults.

* * *

A new member of the Brookings Clinic medical staff is **Dr. Robert E. Shaskey,** a native of Fargo, North Dakota. Dr. Shaskey received his medical degree from the University of Kansas School of Medicine and recently completed a four-year tour of duty with the U. S. Navy.

M. W. PANGBURN, M.D. RETIRES

Dr. M. W. Pangburn, Miller, announced his retirement from active medical practice effective July 13. Dr. Pangburn, who had practiced in Miller for 33 years, indicated that he was doing so because of his health. He plans to stay in Miller, except when the cold breezes blow, and plans to alternate living in that community and in the South.

MEDICAL SCHOOL NEWS NOTES

New staff appointees at the University of South Dakota School of Medicine are:

James N. Adams, Ph.D., Assistant Professor of Microbiology. Dr. Adams was at the University of Georgia as Assistant Professor of their Department of Microbiology.

Thomas A. Anderson, Ph.D., Assistant Professor in Biochemistry. Dr. Anderson has just recently been a senior scientist with Smith, Kline and French Pharmaceutical Company in Philadelphia.

Keith H. Byington has been appointed as an Instructor in the Department of Physiology and Pharmacology. Mr. Byington has received his Masters degree from this institution and will receive his Ph.D. degree from here at an early date.

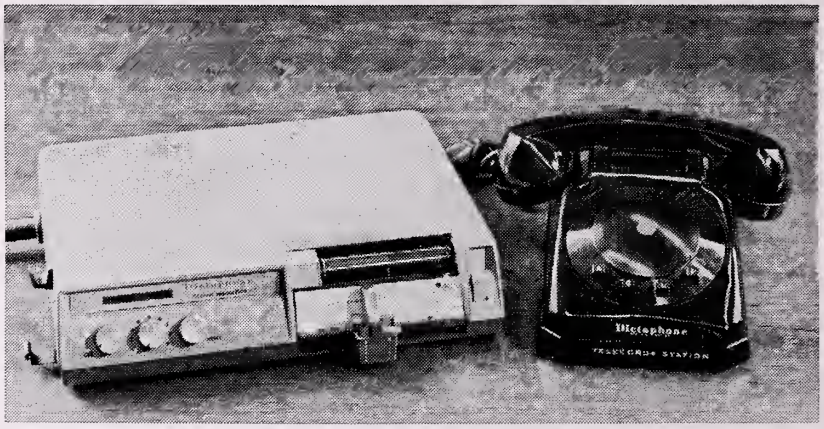
John P. Manning, Ph.D., Assistant Professor in Anatomy. Dr. Manning has been at the Medical College of Virginia where his work has been concentrated in the field of histochemistry.

Joseph D. Welty has also been appointed as an Instructor in the Department of Physiology and Pharmacology. Mr. Welty has received his Masters degree from this institution and will receive his Ph.D. degree from here at an early date.

An electron microscope has been installed in the Department of Anatomy made possible by a grant from the United States Public Health Service to Dr. Earl B. Scott, Professor of Anatomy.

V. A. Zanderson, M.D., recently opened his practice in Parker, South Dakota. He has previously practiced in Sioux Falls, Herreid and Woonsocket.

Doctor, NOW You Can Dictate As Easily as Telephoning



Every doctor uses the telephone for oral communication. Now dictation can be phoned just as easily — with typewritten copies the quick end result.

Dictaphone Telecord is a model of the famous Time-Master line, the world's finest and most valuable dictating machine. Transistors offer reliable, trouble-free operation.

Why not arrange for a demonstration today, from

MIDWEST-BEACH CO., SIOUX FALLS, S. D.

Mr. Merle Pounds, president of the local chapter of SAMA at the University, served on the Legislative Committee of the national organization at their recent national meeting.

* * *

NURSING HOMES TO RECEIVE NATIONAL ACCREDITATION

A National Council for the Accreditation of Nursing Homes, jointly sponsored by the American Medical Association and the American Nursing Home Association, has been organized to carry out a nationwide program to promote high standards among nursing homes.

Organization of the new council, including the appointment of a nine-member Board of Directors, was completed at a meeting of representatives of the AMA and the ANHA in Chicago this week.

The Board of Directors is composed of five physicians and four owners and operators of nursing homes.

Physician members are Dr. H. Close Hesseltine, Chicago; Dr. Pierre Salmon, San Mateo, Calif.; Dr. Wilson T. Sowder, Florida State Health Officer, Jacksonville, Fla.; Dr. Thomas McCreary, Rochester, Pa., and Dr. Frederick C. Swartz, East Lansing, Mich.

Nursing home representatives on the board are Alton Barlow, Canton; N. Y.; Mrs. Eleanor Baird, New Milford, Conn.; Mrs. Vesta Bowden, Denver, Colo., and Mrs. Pauline Williams, Phoenix, Arizona.

The National Council for the Accreditation of Nursing Homes will be headquartered in Chicago, with a full-time executive director to administer the program. The executive director has not yet been selected.

* * *

75 ATTEND PATH WORKSHOP

Over seventy-five medical technologists and technicians from South Dakota and nearby Iowa and Nebraska attended the second annual Clinical Pathology Workshops held at the University of South Dakota School of Medicine in Vermillion, May 16, 17, 18, 1963.

Miss Eleanor Amberg, Mrs. Jane Swanson and Mrs. Helen Arndt, technologists of the Minneapolis War Memorial Blood Bank, presented a workshop on naturally occurring antibodies in the blood. The participants were taught how to perform a wide variety of immunological tests to assure that blood for transfusion will be safe for the recipient. Mr. Charles H. Humes, Technical Director of Coleman Instruments, Inc., Maywood, Ill., led registrants to his workshops through an exercise in adjusting and reassembling a spectrophotometer, a scientific instrument required for many chemical analyses performed routinely in hospital and clinic laboratories.

Practical Diagnostic Bacteriology was the subject of workshops presented by Dr. Harry M. McFadden, Professor and Chairman of the Department of Medical Microbiology, University of Nebraska College of Medicine. In a talk to all in attendance on Thursday, Dr. McFadden described techniques for studying the sensitivity of disease-causing bacteria to modern antibiotics and for evaluating the patients response to these drugs when used in treatment. Mr. B. H. Carpenter of the technical staff of Hyland Laboratories of Los Angeles discussed and presented workshops on new immunochemical diagnostic methods which enable technicians in small hospitals and doctors offices to perform simplified versions of highly complex laboratory analyses to confirm diseases such as rheumatoid arthritis, lupus erythematosis and thyroid inflammation. A new 4-hour test for pregnancy was demonstrated.

Dr. Willard O. Read, Professor and Chairman of the University's Department of Physiology and Pharmacology presented a workshop on fundamentals of electrocardiography and determination of the basal metabolism rate. In a talk to all technicians he called attention to certain mechanical and electrical errors in electric cardiography technique which could give a physician the impression that heart disease was present in a person who was really normal.

The South Dakota Division of the American Cancer Society was sponsor of a three day session on hematology directed by Miss Geneva A. Daland, formerly chief medical technologist at the Thorndike Memorial Laboratory of the Boston City Hospital and presently lecturer in hematology to several in-

stitutions including Northeastern University and Tufts Medical School. Miss Daland stressed the importance, in examining the blood smear for differentiating leukemia from other diseases in which the blood may present a leukemoid or "leukemia-like" appearance.

The program consisted of six different workshops on medical laboratory technique running simultaneously on Thursday afternoon and all-day Friday. Thursday and Saturday mornings were devoted to lectures by workshop directors to the assembled participants.

Sponsors were the South Dakota State Medical Association, South Dakota Society of Pathologists, South Dakota Society of Medical Technologists, South Dakota Division of the American Cancer Society and the University of South Dakota.

The workshops were well received by those attending. The South Dakota Society of Medical Technologists, at their annual meeting held on May 16, expressed the desire to continue this program annually at the University for the next five years.

* * *

A five-day course in "Sources and Use of Toxicological Information" will be presented by the Institute of Industrial Medicine, New York University Medical Center, in cooperation with the American Industrial Hygiene Association Oct. 14 through the 18th, 1963. Inquiries for additional information should be addressed to: Institute of Industrial Medicine, New York University Medical Center, 550 First Avenue, New York 16, N. Y.

* *



BACK ROW, LEFT TO RIGHT: Mrs. Irene Schade, Huron; Mrs. Rita Grohs, Mitchell; Mrs. Laureina Geyerman, Huron, and Mrs. Dorothy Preheim, Freeman.

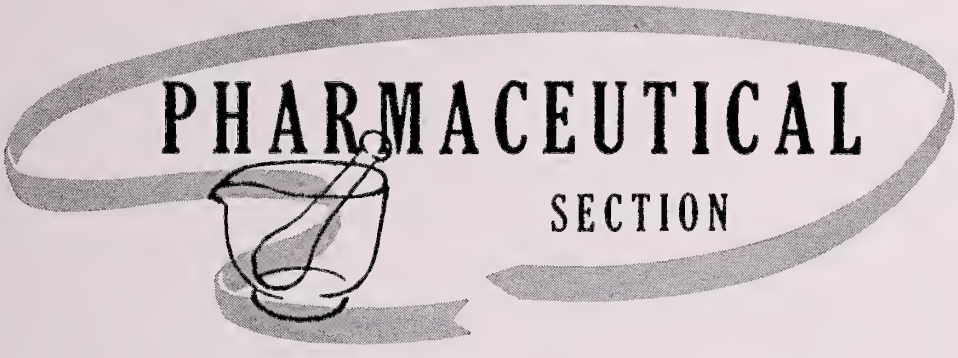
FRONT ROW, LEFT TO RIGHT: Sgt. Hugh Loy, Rapid City, and Mrs. Clara Lobdell, Rapid City, outgoing President.

The Seventh Annual meeting of the South Dakota Medical Assistants was held at Chef Louie's Cafe in Mitchell, South Dakota, on Saturday, May 18, 1963.

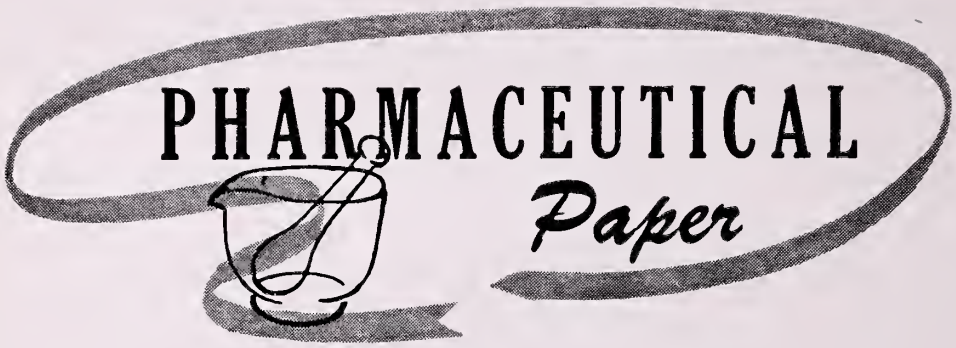
The business meeting started the morning off with election of officers, and reports from all groups. The noon luncheon was held at 12:00 noon at which time the group enjoyed a talk on "Women in Business" by Mrs. Iola Hathaway who is President of Association of Credit Bureau of the Upper Midwest; this was followed by a talk by the Upjohn Representative, Mr. Walter Thieme who talked on "Drugs and Your Health"; the afternoon session was brought to a close with a talk by Dr. H. R. Lewis of Mitchell on Physical Fitness.

The evening banquet was held that evening at which time the following new officers were installed: Sgt. Hugh Loy, Rapid City, President; Mrs. Dorothy Preheim, Freeman, President Elect; Mrs. Irene Schade, Huron, Recording Secretary; Mrs. Rita Grohs, Mitchell, Treasurer; Mrs. Laureina Geyerman, Huron, Corresponding Secretary. The speakers at the banquet were Mr. Louis Kimball, the Executive Director of Mental Health Association, and Mrs. Sally Purchell, Psychiatric Social Worker, both of Huron, and their topic was, "The Team of Enablers."

The meeting was adjourned until the 8th annual meeting which will be held in Rapid City in 1964.



GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota



REPORT TO THE S.D.Ph.A. ON TRADE REGULATION ACTIVITIES BY THE FEDERAL GOVERNMENT*

by
Sigurd Anderson**
Washington, D. C.

Mr. President, Distinguished Guests, Officers, Members and Guests of the South Dakota State Pharmaceutical Association here gathered in annual convention: It is a pleasure and an honor to be with you on this occasion, for the reason that we are all friends and neighbors. I am sorry to note the absence of members of the Association who have gone to a better land. At the same time, I am happy to note so many new faces and names of men and women who have cast their lot with pharmacy in the State of South Dakota.

It goes without saying that it's a pleasure to be back home again in South Dakota. It is a special pleasure to be back here in Pierre, which is not only centrally located geographically but centrally located government-wise because it is the heart of State Government of South Dakota. I hope that this 77th Annual Convention of the S.D.Ph.A. has been most successful up to now.

When your Secretary, Bliss Wilson, extended your invitation to come here, I accepted without argument, because I was quite aware of the important place of the drugstore in the life of South Dakota and the important position that the druggists hold in our State. In South Dakota, as indeed elsewhere in the Nation, the drugstore is not just a store — the drugstore is an institution. Our country would be poorer were it not for the drugstore. The drugstore is the place where come the sick, the ailing, for prescriptions or for proprietary preparations; where come the tiny tots for candy; where come the young folks for rendezvous. In fact and in short, everybody comes to the drugstore. The feet of America track into your drugstore. You druggists are the confidants of the sick, the near sick, the doctor and his patient, young and old, rich and poor. You occupy the important position of adviser to America. I think it may be said that you are more important than you think. With this position goes great responsibility, indeed, and I know that every druggist is constantly being called upon to give advice on practically every subject under the sun. And speaking of advice, I am reminded of a story of a man in prison

*A speech delivered at the 77th Annual Convention of the South Dakota Pharmaceutical Association, Holiday Inn, Pierre, South Dakota, June 24, 1963

**Commissioner, Federal Trade Commission.

who called his lawyer. He said, "I need some advice! They have just come into my cell; they slit my trouser legs; they shaved my head — what shall I do?" to which the lawyer responded, "For Heaven's sake! Don't sit down."

As I look back over the years, it is readily apparent that drugstores have played an important role in my life. Not only have the druggist and the drugstore provided me with medicine for my aches and pains, but just about 50 percent of everything else that I use. My earliest recollection about free reading material is of the drugstore operated by Sherman and Roche at Canton, which later was taken over by Jones and Anderson. I recall that D. F. Dexter, the father of the present First Lady of South Dakota, operated a fine drugstore in Canton. In fact, it was in his drugstore that I first learned the value of cash. As a little boy hardly able to speak English I was in his place admiring a bar of candy one night just before closing time and I asked him how much it was, and he said 10 cents, and I didn't have 10 cents, and he said, "How much do you have?" I said, "A nickel." So, I got a 10-cent bar of candy for a nickel. That's the first discount transaction that I ever engaged in. I also recall the Noid Drugstore at Canton that operates to this day. A new crop of druggists has come in. I recall the druggists in my hometown of Webster — Cornwell Drugs and Halbkat Drugstore — two wonderful drugstores. And I mustn't forget the drugstores in Rapid City, especially those formerly operated by my good friend Roy Doherty, that peripatetic and vigorous booster for South Dakota now a longtime member of the Public Utilities Commission of South Dakota. I remember that I bought a fishing rod from Roy 31 years ago. I still have the rod, and every time I look at it I always think of Roy and recall the day I bought it. He said, "This is one of the best rods built." As I was a member of the faculty of the Rapid City Public Schools, he gave me a slight discount. An enumeration of drugstores would be utterly incomplete if we didn't mention that amazing institution at Wall, South Dakota, operated by Ted Hustead. As a farm boy of 40 years ago, I recall going into Bruhler and Bruhler at Beresford and ending a hot week with a gooey banana split. I read with interest some time ago that Mr. Bruhler is still operating that drugstore. I recall once upon a time that I was in Harry Lee's drugstore over in Alcester. I also recall the drugstore that Mark Wilkins operated at Bancroft, South Dakota, before he moved to Clark. Coming back to my own county of Day, I spent many a pleasant hour in John Greening's drugstore in Waubay and Knutson's drugstore at Bristol and Cliff Shannon's drugstore at Pierpont. An old friend of mine, Julian Pearson, who used to be a druggist at Webster, operates a fine drugstore at Sisseton. Many years ago, while a student at South Dakota State College, I served as a member of the freshman class with Kerm Buechle, who has a drugstore at De Smet. At that time I recall a very pretty girl named Nina Olson, who later owned and operated a drugstore at Oldham. My recollections of State College days are to the effect that the worst drilled military company in the R.O.T.C. there was the Pharmic Company. They were utterly impossible. It was an hilarious experience to watch them march. Coming back to our capital city, I recall the fine drugstores operated by Red Zarecky, an 18-hour-a-day worker, and the stores operated by "Snooks" Herzog, Freddy Vilas and Frank Kelley. I must not forget the drugstore in Yankton run by Harold Tisher, my old S.D.S.C. classmate. Another fine institution where I have spent money is Ray Cash's drugstore in Vermillion — Ray and I were S.D.S.C. schoolmates. I also recall Davis Drugs of Vermillion, operated by "Hack" Davis, who was an old S.D.U. classmate. I recall so well Lewis Drugs, Mills Drugs, Kendall Drugs, Brown Drugs, Humphrey Drugs, Perriton Drugs, and hosts of others. I think I have been in almost every drugstore in South Dakota. This enumeration of drugstores is getting to be too extensive. I hadn't intended to go into it. I am afraid that I have missed a lot of fine drugstores, but I want you to know that I have every one of you in mind.

I regret to say that no one advised me how long I could talk on this occasion. The failure to indicate the length of a speech could indeed be regrettable for the program committee. This situation somewhat reminds me of the story of the chap who got up to give a speech at a Kiwanis Club meeting and he

didn't know how long he should talk, so he turned to the president and said, "Mr. President, how long may I speak?" And the president of the club responded by saying, "You can speak just as long as you want to, but at 1:30 we get up and go."

The subject that I would like to discuss for your consideration is, "Report to the S.D.-Ph.A. on Trade Regulation Activities by the Federal Government." In view of the fact that there is a great deal of trade regulation work in progress by the various agencies of the Federal Government, and not to leave out the important and effective work of state and local enforcement agencies, I felt that a report about trade regulation enforcement by the Federal Government with special reference to the Federal Trade Commission, might be of interest to this group. During the last half century, trade regulation in the United States has been greatly stepped up. With a noticeable population increase, as well as augmented competition in all American industries, there has resulted an expanded and more penetrating trade enforcement program. I suppose that this is almost a natural consequence. Like you, I deplore the increase in government activity and impact upon the citizen, but it seems like it's pretty hard to keep government from growing. That is true of government on every level — national, state and local.

What Is the Federal Trade Commission and What Does It Do?

It might be beneficial to tell you a little bit about the Federal Trade Commission in order that you may have a better understanding of trade regulation. The Federal Trade Commission is a quasi-judicial body of the Federal Government vested with judicial, legislative and administrative powers. It was created in 1914. As you will recall, there were two important events that occurred that year: (1) the Federal Trade Commission was created; and (2) World War I began. There are some elements of American business who are of the opinion that the Commission has been as devastating as World War I. The governing body of the Commission is composed of five Commissioners who are appointed for a seven-year term by the President and confirmed by the Senate. At the present time, the Commission has a personnel membership of 1,151. Of this number, 452 are lawyers, 40 are economists, 21 are accountants, and 638 are doctors, scientists, statisticians, secretaries, stenographers, clerks, messengers and administrative detail people. The Commission has 11 branch offices, located at Atlanta, Georgia; Boston, Massachusetts; Chicago, Illinois; Cleveland, Ohio; Kansas City, Missouri; Los Angeles, California; New Orleans, Louisiana; New York, New York; San Francisco, California; Seattle, Washington; and Washington, D. C.

The powers of the Federal Trade Commission are not punitive in the sense that violators of the laws enforced by the Commission are proceeded against like criminals. The Commission's power is injunctive in nature; that is, the Commission employs its power to compel a violator to cease and desist from continuing the practice which has been found to be unlawful. In other words, the Commission, instead of prosecuting violators of the law, proceeds against violators and makes them stop the practices currently found to be unlawful. One of the great advantages of the Commission's powers is that it has the authority to stop practices before they become "full-blown," as we say. This stopping illegal practices in their incipiency is of great benefit to the public and rather distressing to those against whom the charges are brought. The orders to cease and desist may run in perpetuity. Orders may be entered against a violator either by consent or as a result of adversary proceedings. Some of the cases are settled very quickly. Other cases are hard fought and take a long time.

In the event orders of the Commission are violated by those against whom they are issued, the Commission may seek civil penalties for such violations. Under the law, the penalty for the violation of a Commission order is $5,000 per violation per day. You can see that this could add up to a considerable amount of money where violations of the order have been going on for some time. The other day the Commission recommended action against a perfume company for $185,000 in penalties.

Should you wish to gain any information about the Commission and how it operates,

I invite you to request such information by writing the Commission as follows: Federal Trade Commission, 6th and Pennsylvania Avenue, N. W., Washington 25, D. C. The Commission publishes many reports, pamphlets and other informative material. It also issues press releases on current subjects. I am sure that your Secretary, Bliss Wilson, is currently receiving press releases in connection with our activities in the field of health, food, drugs and cosmetics.

Division of Commission Activity

As is customary with all agencies of Government, we divide our work into several logical areas. Our two main types of activities are in the fields of restraint of trade and deceptive acts and practices. Restraint of trade has reference to such acts as unlawful conspiracies to fix prices, divide territory and the like. Also included in this area are price discriminations, illegal brokerages, unlawful promotional allowances, illegal mergers of corporations in interstate commerce, exclusive dealing arrangements, and also unlawful solicitations of discriminatory prices and unproportionalized promotional allowances. I shall not devote much time to a discussion of this area of our work except to say that last year the Commission brought an action against the Community Blood Bank of the Kansas City Area, Inc., et al., charging the respondents, both corporate and individual, with having entered into a conspiracy not to use blood of another blood bank. This case is a case of vast proportions and is currently in process of trial. For that reason, I cannot comment about it.

The area where the Commission has been most active insofar as the interests of your organization would be concerned is in the field of health where it has proceeded against deceptive acts and practices running into the hundreds, if not thousands.

It goes without saying that one of the most important resources that a human being has is good health. When ill health sets in, the average person will spend any amount of money to recover his or her good health. I wonder how many crimes have been committed in the name of health and healing? They must indeed be beyond count. I am sure that you have in mind numberless instances where persons, who had lost their health, have grasped at "straws" in order to recover their health. Some of these "straws" that have been grasped are unbelievable. Some of the cures offered to a suffering public are almost beyond belief. With your permission, I would like to enumerate some of the "cures" against which the Commission has proceeded.

A. Arthritis
   1. Pills that are little more than aspirin.
   2. Metal heel plates to be worn in shoes to cure arthritis.
   3. Copper and zinc bracelets and wristlets to be worn by arthritis victims to eliminate arthritis.
   4. Uranium mine cures — victim to sit in uranium mine and let ores penetrate body so that victim is cured.
   5. Uranium pillow — pillow containing crushed uranium ore which, when used by victim, will alleviate arthritis in neck and shoulders.

B. Rheumatism
   1. Just about as many as in the case of arthritis.

C. Baldness
   1. This is an area for "operators." Experts have testified that 85% to 95% of all baldness is male pattern baldness; that is, it is something that comes through the family lines. Heredity plays an important part in this "aggravation." The best thing to do in order to avoid baldness is to select one's ancestors more carefully.

D. Obesity
   1. This is indeed a problem. Too many Americans have been and are living "too high on the hog," as they say down South. Experts, and others who are knowledgeable on the subject, claim that the only cure of or prevention of obesity is to cut down on caloric intake. There are, of course, cases where glandular problems must be considered but, in the main, if a person who is disposed to be obese wishes to prevent an overweight condition, he or she must just practice Spartan eating habits. This is, of course, not very good news to people who like to eat.

2. Speaking of losing weight, have you heard the story of the man who lost 135 pounds in one day? His wife left him!

The Commission has proceeded in hundreds of cases to prevent the use of false advertising of products offered as having health benefits. For example, in recent months the Commission has issued orders prohibiting use of practices such as:

Advertising of a drug preparation as a cure for rheumatism, arthritis, insomnia, constipation, and blindness.

Advertising a drug for asthma as being safe and having no adverse side effects.

Advertising of yogurt as a treatment and cure for gastro-intestinal disorders.

Misrepresenting the adequacy of control systems used in drug manufacture.

False advertising as to accuracy of a device for fitting contact lenses sold by mail.

Misrepresenting the reliability of a birth control calculator.

False advertising as to efficacy of a bed-wetting preventive.

Advertising that shoes will correct, prevent or relieve arthritis, high blood pressure, indigestion, and stomach ulcers.

Advertising that "_____ Double-Buffered Cold Tablets" will cure or shorten the duration of a common cold.

Advertising that a drug preparation, "_____," will cure alcoholism.

Advertising that a "Height Increase System" will increase one's height.

Advertising an amazing new pep pill.

Perhaps the most flagrant case of false advertising ever encountered by the Commission was that involving two citizens of Detroit, Michigan. The order as affirmed by the courts in that case prohibited claims that a drug product, a single product, mind you, constituted an adequate treatment for cancer, leprosy, malaria, coronary thrombosis and occlusion, multiple sclerosis, arteriosclerosis, asthma, hay fever, epilepsy, psoriasis, poliomyelitis, tuberculosis, syphilis, arthritis, and insanity. The Commission found that the product would be of no benefit in the treatment of any disease of the human body or in animals.

I call to your attention an observation recently made by Dr. George Larrick, commissioner of Food and Drug Administration, to the effect that the American people spend a billion dollars a year for useless drugs and foods in the belief they are beneficial to their health.

The Commission's authority to prevent false advertising of food, drugs, medical devices and cosmetics, extends to requiring affirmative disclosures in advertising when necessary to prevent deception. For example, the Commission has taken action to require that advertisements offering vitamin-mineral preparations for tiredness and nervousness contain disclosure that in the great majority of persons these symptoms would be due to conditions other than vitamin or mineral deficiency, and that in such cases the taking of a vitamin or mineral preparation would be of no benefit. The theory of this type of action is that the symptoms may be due to some serious underlying disease or condition, and that possibly dangerous consequences might result from continued self-treatment of such diseases and conditions.

Along the same line, the Commission has accepted a consent order to prevent the advertising of "New Super Hadacol" for iron deficiency anemia unless disclosure be made that in women beyond the child-bearing age, and in men of all ages, iron deficiency anemia is almost always due to bleeding from some serious disease or disorder and, in the absence of adequate treatment of the underlying cause of the bleeding, the use of the preparation may mask the signs and symptoms and thereby permit the progression of such disease or disorder. A similar question has been raised in formal complaint issued with regard to advertising of the product designated "Geritol"; that case is still in process of trial and has not been settled.

The Commission has also taken action under its general authority to prevent unfair and deceptive practices, as necessary to protect the public health. For example, orders have been issued to prevent false claims of safety and to require warning of possible danger in use of toys and plastic metal menders. In such cases, the Commission maintains close liaison with the Food and Drug

Administration to avoid duplication or conflict of effort in relation to that agency's responsibility to prevent deceptive labeling of food, drugs, medical devices, cosmetics, and hazardous household substances.

There are a number of recent developments in the field of trade regulation that might interest you. I want to call your attention to a number of cases that the Department of Justice brought against pharmaceutical associations. These were: **United States v. Northern California Pharmaceutical Association; United States v. Utah Pharmaceutical Assocation; United States v. Arizona Pharmaceutical Association;** and **United States v. Idaho Pharmaceutical Association.** As you know, in each of these cases the association was charged with having violated the Sherman Antitrust Act for having fixed prices of prescriptions.

In **United States v. Utah Pharmaceutical Association,** 201 F. Supp. 29, tried in the U. S. District Court for the District of Utah, it was held that an association of pharmacists violated the Sherman Antitrust Act by adopting retail price schedules for prescription drugs, distributing them to members in the state, and urging and inducing them to use the schedules for the pricing of prescription drugs, with the intent of establishing uniform prices within the State. The fact that the schedules were not used exclusively by members did not militate against the conspiracy nor the intent of the association to promote the use of the schedule to stabilize prices. These activities of the association were held to be illegal per se. The case was taken to the Supreme Court, and on October 15, 1962, the Supreme Court in a three-line per curiam opinion affirmed the action of the District Court.

In **United States v. Northern California Pharmaceutical Association and Donald K. Hedgpeth,** the members of the Association and its secretary were indicted for violation of the Sherman Antitrust Act for price fixing. A civil case against the same defendants was later brought for violation of the Sherman Antitrust Act for price fixing. The defendants took a consent decree on April 9, 1963, the terms of which are somewhat similar to that entered into by the Idaho group. In the criminal case, the Association and its secretary were found guilty by a jury in the Federal District Court of illegal price fixing activities concerning prescription drugs. Judge Goodman sentenced the Association to pay a fine of $50,000 and imposed a 30-day jail sentence and a $5,000 fine against the secretary. The defendants subsequently appealed to the United States Court of Appeals for the Ninth Circuit. The Circuit Court denied the appeal. Following the denial of this appeal, the defendants petitioned the United States Supreme Court for a writ of certiorari. This writ was subsequently denied on October 15, 1962.

Last June the Justice Department filed a civil complaint in Phoenix, Arizona, charging the Arizona Pharmaceutical Association, the Maricopa County Pharmaceutical Association, both of Phoenix, and the Tucson Pharmaceutical Association, Tucson, Arizona, with conspiracy to fix prices. The case has not yet been tried, as far as I have been able to find out.

In 1961 the Department of Justice filed a civil complaint against the Idaho State Pharmaceutical Association, charging them with conspiracy to fix prices for prescription drugs. The defendant did not resist and took a consent decree, which was entered April 5, 1963. By the decree the defendant was prohibited from fixing prices for prescription drugs, formulating and distributing prescription pricing schedules, urging members to adhere to prescription pricing schedules, and contacting pharmacists to fix prescription drug prices.

Quality Stabilization

During the past several sessions of Congress there have been introduced a number of bills known as the "Quality Stabilization" bills. These legislative proposals, calculated to promote "quality and price stabilization," would, in effect, establish federal re-sale price maintenance for goods subject to distinguishing brands, names or trademarks. In effect, the Quality Stabilization Bills provide that the manufacturer of trademarked or brand-named goods, in competition with other goods of similar nature, may revoke the right of any person (whether it be a wholesaler or a retailer) to resell such goods

at prices other than those established and determined by the manufacturer thereof. In addition, the manufacturer would be granted the right to bring civil actions against such resellers to restrain price cutting and to recover damages therefor.

The Federal Trade Commission has for many years expressed opposition to such bills on the grounds that such bills are prejudicial to the interests of consumers by denying price competition in the resale of such goods; they facilitate price agreements between manufacturers and between distributors; they place the small retailer at a competitive disadvantage vis-a-vis the large chain stores who have the resources to procure and sell privately branded goods in competition with the branded goods of various manufacturers.

Many of the states, however, have on their statute books "State Fair Trade Acts." Such statutes are permissible under the Miller-Tydings Amendment to the Sherman Act, and the McGuire Act of 1952, as an amendment to the Federal Trade Commission Act. South Dakota is one of such states.

State fair trade laws generally provide that no contract or agreement relating to the resale of a commodity which bears the trademark, brand or name of the producer of such commodity, which commodity is in free and open competition with commodities of the same general class produced or distributed by others, shall be deemed in violation of any laws of the state by reason of specified provisions thereof. One of those provisions relates to the establishment, by the producer, of minimum stipulated resale prices.

The South Dakota Fair Trade law was upheld as constitutional many years ago in that well-known case of **Miles Laboratories, Inc. v. Owl Drug Co.,** 67 S. D. 523; 295 N. W. 292 (1940).

Actions Against Analgesic Manufacturers

In 1960, concerned over the fact that numerous advertisers of aspirin and other analgesics were each representing to the public in their advertising that their preparation gave pain relief faster than all others, that theirs caused no stomach upset whereas others did, and that certain of these preparations had tranquilizing and anti-depressant properties, the Commission instituted a research program to determine the facts, with a view to filing false advertising charges against these advertisers if the facts should show such action to be warranted.

In 1960, and subsequent thereto, the Commission entered into contracts with staff members of hospitals and with medical schools to conduct clinical studes into the properties and comparative merits of the preparations.

One of these contracts was with doctors on the staff of Baltimore (Md.) City Hospital and Johns Hopkins School of Medicine (Baltimore, Md.), and a medical statistician of the Baltimore City Health Department.

Following completion of this particular study the researchers requested of the Commission, and were granted, permission to report their findings in an article that would be published in The Journal of the American Medical Association.

The article appeared in The Journal of December 29, 1962. Under the heading "Comment" it was stated:

> "On the basis of this study, it seems that, within the limits of generalization permitted by the population studied, there are no important differences among the compounds studied in rapidity of onset, degree, or duration of analgesia.
>
> "It also appears that, as far as gastrointestinal side-effect liability is concerned, Excedrin and Anacin may cause a higher incidence of gastric upset than Bufferin, Bayer Aspirin, and St. Joseph's Aspirin. The latter three drugs were not significantly different from one another in this respect."

In less than two weeks full-page Bayer Aspirin advertising appeared in at least 128 newspapers throughout the United States. In a complaint which the Commission issued soon thereafter, the Commission alleged it had reason to believe the advertising was misleading in having represented:

1. That the findings of the medical team of clinical investigators referred to in said advertisements have been endorsed and approved by the United States Government.
2. That the publication of a report of said study, together with the findings of the

clinical investigators, in The Journal of The American Medical Association, is evidence of endorsement and approval thereof by that association and by the medical profession.

3. That the clinical investigators found that Bayer Aspirin will not upset the stomach, is as gentle to the stomach as a sugar pill and is more gentle to the stomach than any analgesic product containing more than one ingredient, and that there is no analgesic product available to the consumer which is more gentle to the stomach than Bayer Aspirin.

4. That the clinical investigators concluded that Bayer Aspirin, after fifteen minutes following administration, affords a higher degree of pain relief than any other product tested.

Also, because the Federal Trade Commission Act states (Sec. 13) that whenever the Commission has reason to believe that a company is engaged in disseminating false advertisements of a drug and that the enjoining of such dissemination pending a final determination of its administrative complaint procedures would be in the public interest, it may bring suit in a United States District Court for a temporary injunction, the Commission in this instance sought an injunction. Both the District Court and the Court of Appeals concluded, however, that the facts did not warrant an injunction.

The Sterling Company having denied the charges contained in the Commission's administrative complaint, the matter is, accordingly, being fully litigated in a Commission proceeding.

On January 21st, Plough, Inc., manufacturer of St. Joseph's Aspirin, embarked on a similar wide-scale, full-page newspaper advertising campaign. Again, the Commission thought it had reason to believe that the reported study was not truthfully represented, and a second complaint issued. That complaint charges Plough with having falsely represented that the report reflected the views of the A.M.A., that the report said St. Joseph's Aspirin was the best buy in pain relief and that the product caused no noticeable stomach upset.

This company has also denied the charges and this matter is also now in the litigation stage.

Advisory Opinions

The Federal Trade Commission has recently developed a program to render advisory opinions concerning certain business practices. If a person or concern in business wishes to find out in advance as to whether or not the use of a certain business practice is lawful, the Commission will, upon request, advise as to the lawfulness or unlawfulness of the proposed action. The applicant must carefully and fully explain the proposal. Please note that existing programs cannot be considered. Only proposed courses of action will be ruled upon by the Commission. The device of the advisory opinion should be very helpful for those engaged in interstate commerce. Should your secretary have occasion to raise such a question of the Commission, our organization will be most happy to oblige. To date, the Commission has rendered 53 advisory opinions dealing with such subjects as tripartite cooperative advertising programs, country of origin markings, pricing programs, and the like.

Advisory Opinion on Joint Advertisements

Of considerable interest to this group, I am sure, is the recent Advisory Opinion rendered by a majority of the Commissioners with reference to the legality of a proposed promotional program designed to enable small independent druggists to utilize cooperative advertising allowances through the medium of joint advertising. Since the Commission's opinion in this matter has received widespread publicity in the press and in the trade journals and has also been the subject of hearings by the Select Committee on Small Business of the House of Representatives, I would like to give you a brief resume of the circumstances which gave rise to this opinion and the legal basis for the views expressed by the majority.

This particular matter arose from two different sources — (1) a request by Marketing Programs, Inc., the originator of the plan, for a ruling from the Department of Justice, and (2) a request from the antitrust counsel of the National Association of Retail Druggists for an opinion as to the legality of participation in the program by various state, regional

and local pharmaceutical associations to which the program had been presented. Through our established liaison procedures, it was agreed that both requests, since they dealt with the same basic subject, should be considered by the Commission instead of the Department of Justice.

Basically, the plan in question contemplated the designation of Marketing Programs, Inc., as the agent for various groups of retail druggists for the purpose of collecting cooperative advertising allowances to which they were legally entitled but which could not be or had not been effectively utilized by each individual druggist because of the relatively small amounts involved. Once obtained, these allowances were then to be pooled for the purpose of publishing joint advertisements which would list certain featured items, together with the names of the participating druggists.

The specific proposal upon which the Commission's opinion was based clearly indicated that the items to be featured each week, as well as the prices to be listed, would be selected and designated by a Committee of Retail Druggists. It was further proposed that this Committee, acting as the representative for the entire group, would also select certain items to be featured as "loss leaders."

Faced with these facts, a majority of the Commission felt that there could be only one answer from a strictly legal standpoint regardless of the laudable objective of enabling small druggists to compete more effectively with their chain and discount house competition.

As many of you know, it is a well settled principle that price fixing is unlawful, per se. Furthermore, price fixing is not only a violation of Section 5 of the Federal Trade Commission Act, which prohibits unfair methods of competition, but is also violative of Section 1 of the Sherman Act, under which both civil and criminal actions may be brought.

Under these circumstances, a majority of the Commission felt that the opinion which was rendered, namely, that participation in the plan would raise serious questions of law violation — was impelled by the facts and the applicable legal principles, and that any reply other than that which was given might mislead the requesting parties as to the legality of the plan under applicable federal statutes.

As disturbing as our advice may have been in this particular instance, we feel that we are bound by the law as enacted by the Congress and interpreted by the courts and that to render a contrary opinion merely because our sympathies lie with small business in its competitive struggles, would have been a disservice to the parties who requested our views on this subject.

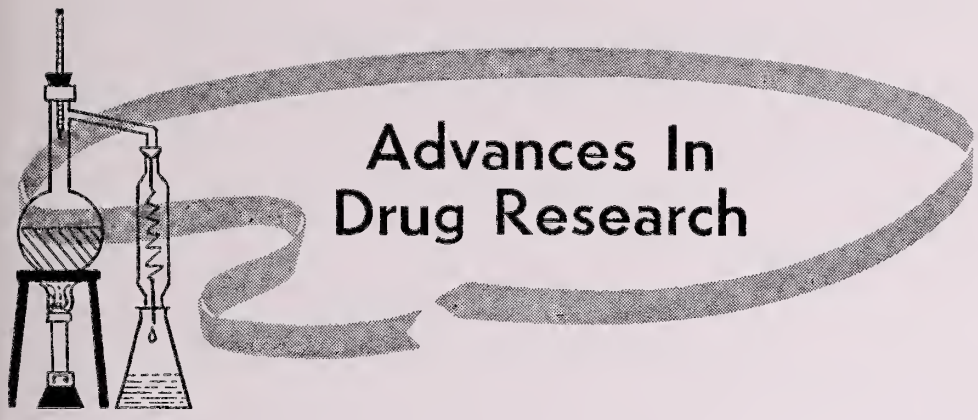
Guides

The Federal Trade Commission has also developed Guides for businessmen. To date, ten Guides have been prepared. These Guides are very helpful, and I suggest that you secure copies of them. I have some samples with me. The Guides that are now available are as follows:

- Cigarette Advertising Guides
- Tire Advertising Guides
- Guides Against Deceptive Pricing
- Guides Against Bait Advertising
- Guides Against Deceptive Advertising of Guarantees
- Guides for Advertising Allowances and other Merchandising Payments and Services; Compliance with Sections 2(d) and 2(e) of the Clayton Act, as amended by the Robinson-Patman Act
- Guides for Advertising Fallout Shelters
- Guides for Advertising Shell Homes
- Guides for Shoe Content Labeling and Advertising
- Guides for Advertising Radiation Monitoring Instruments

The Guide program, in the words of the Commission, "is designed to accomplish two principal objectives: (1) To spell out in readable, easily understood language the requirements of the law applicable to different types of advertising practices under the Federal Trade Commission Act and discriminatory practices under the Robinson-Patman Act, and (2) by the diligent administration of the former, to see that a maximum degree of voluntary compliance with the law is obtained. Where voluntary compliance cannot be obtained, the Guides serve the additional

(Continued on page 50)



MAJOR DEVELOPMENTS IN THE PHARMACEUTICAL SCIENCES DURING 1962 REVIEWED

A comprehensive review of the more significant developments in the pharmaceutical sciences reported during 1962 has been specially prepared to serve as a medium for interdisciplinary communication between pharmaceutical scientists, pharmacists, and others interested in keeping abreast with recent technical and scientific advances. Dr. Wayne McKeehan of the Lilly Research Laboratories is the author of this 30-page work which appears in the July and August issues of the Journal of Pharmaceutical Sciences.

The review is confined to literature reports of interest to pharmacy which are not adequately covered in numerous annual review series. Pertinent data has been culled from 984 individual reports and incorporated into Dr. McKeehan's systematic and organized format for ready reference.

Part I in the July issue treats general pharmacy — preservatives, flavoring, adjuvants, stability, stability kinetics, and vitamin stability; pharmaceutical technology — tablets, emulsions, suppositories, ointments, suspensions, sterility, packaging, and aerosols; physical pharmacy — solubility, complexation, surface phenomena, and rheology; and pharmaceutical chemistry — antibiotics, ion exchange, polymers, and methodology.

Part II in the August issue covers radioisotopes; biopharmaceutics — effects of formulation, effects of physicochemical properties, effect of particle size, absorption control, kinetic studies, absorption mechanisms, drug absorption (antibiotics, organic, and inorganic); plant chemistry — phytochemical investigations and methodology; and equipment.

The section on general pharmacy in Part I will be of particular interest to community and hospital pharmacists because of its relevance to extemporaneous and small scale preparation, as well as industrial applications. Dr. McKeehan notes the classification of antioxidants according to their mechanism of action, physicochemical aspects of preservative selection for emulsions, influence of light on the stability of pharmaceutical formulations, and effect of surfactants on the stability of some pharmaceuticals among many other developments.

The section on biopharmaceutics in Part II puts advances in biochemistry, pharmacology,

physiology, and other fields of knowledge which are important in ascertaining the effects of pharmaceutical formulation on the biological activity of medicinal agents. Topics covered in this section include biochemical reactions of drug metabolism, importance of pharmaceutical formulation on the clinical efficacy of drugs, methods for determining whether or not a patient is actually taking prescribed medication, relationship between disintegration time and physiological availability of medication in long-acting tablets, mechanisms of drug absorption and excretion, along with many other significant subjects.

In conclusion, the author states that the pharmaceutical scientist will become increasingly dependent on developments in other disciplines as pharmaceutical research becomes more complex and notes that an up-to-date knowledge of the literature provides a sound basis for interdisciplinary communication.

POWDERED CORNCOB SHOWN TO BE A SUPERIOR TABLET DISINTEGRANT

Corncob, considered only as a waste product of corn by most people, may find application in pharmaceutical manufacturing as a tablet disintegrating agent on the basis of data reported by Taghi A. Fakouhi, Norman F. Billups, and Robert W. Sager in the July issue of the Journal of Pharmaceutical Sciences.

In an experiment designed to test a large number of wood products as possible disintegrating agents, the authors discovered that powdered corncob gave shorter disintegration times than several selected disintegrating agents (including cornstarch which is considered to be the best by some authorities). Of the various concentrations of powdered corncob tested in tablet granulations, 10 percent was considered to give the best disintegration properties.

After analyzing the results of the powdered corncob, the authors subjected this material to more intensive study. They found that No. 40-mesh particles produced optimum disintegration times and that corncob still appeared to be superior to starch in acetylsalicylic acid, calcium carbonate, and sulfadiazine tablet granulations.

Since the physical appearance of corncob reveals that it is composed of three distinctive parts — pith, woody substance, and chaff — each of the constituents was subjected to individual tests. The results indicated significant differences in disintegrating action between the three parts (pith was best, then woody substance, then chaff) and raised a question whether the disintegrating action of powdered corncob was due solely to its starch content. After further study it was found that the mixture of cellulose and starch present in corncob constituted a better disintegrating agent than either the starch or cellulose alone.

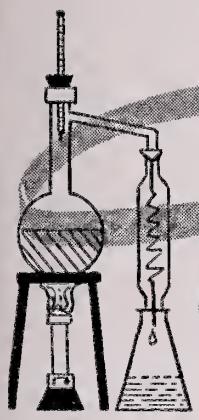
Since all of the disintegrating agents studied operate by absorbing water, swelling, and rupturing the tablet in which they are incorporated, these materials were subjected to moisture absorption studies in a humidity chamber. The results indicated that powdered corncob absorbed more moisture than did starch, a 1:1 mixture of cellulose and starch, or cellulose although all these agents absorbed more moisture than the control.

ANDERSON—(Cont. from page 48)

purpose of spotlighting persistent violations which warrant formal action."

It is beginning to be apparent that this speech is getting pretty long, so I am going to seek terminal facilities. The Federal Trade Commission holds out the hand of cooperation. We offer our help, and we ask for yours. The matter of keeping competition clean, fair and honest is of prime importance in the United States. The best way to make the capitalistic system work — and there is no system better — is to keep competition clean so that a minimum of laws are required to regulate activities of competitors. Here in South Dakota, I feel that we have had a clean and fair competitive spirit and I hope that we keep it that way. You druggists, as leaders in your communities, can do much to help the public and to help the competitive spirit.

It has been a pleasure to come here and be with you. May the years ahead be the best years of your life. Thank you.



Advances In Drug Research

NEW ANTINEOPLASTIC AGENT FROM THE PERIWINKLE PLANT

A new antineoplastic agent which significantly prolonged the survival of children with acute leukemias after their cases had become refractory to other drugs has been introduced by Eli Lilly and Company under the trademark Oncovin (vincristine sulfate).

Oncovin is one of some forty alkaloids obtained from the periwinkle plant (**Vinca rosea** Linn.). It is the second periwinkle alkaloid to be made available to physicians for treating cancer patients. The first was Velban (vinblastine sulfate), which is useful in the treatment of generalized Hodgkin's disease and choriocarcinoma.

Oncovin is obtainable only in minute amounts from the periwinkle plant. For example, depending upon the yields of various shipments from India, it takes from 10 to 15 tons of plant to produce an ounce of the drug. Extraction and purification require four months.

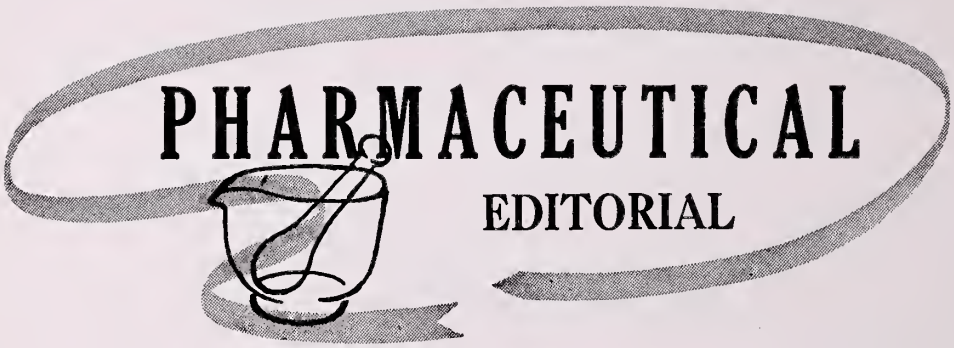
Although investigators have reported Oncovin's activity against a wide variety of neoplasms, at present the available data support its use only in the acute leukemias of children. It has not been approved by the Food and Drug Administration for treatment of neoplasms in adults or of other neoplasms in children.

Six research centers studied Oncovin in 104 children with acute leukemia. Among 95 patients in whom the drug had an adequate trial and evaluation, 37 (39.0 percent) had complete remissions of disease; and 29 (30.5 percent), partial remissions. In 29 (30.5 percent) there was no response.

Thirty patients were still in remission at the time the clinical reports from the six research centers were summarized, the remissions ranging from seven to 112 days.

Analysis of the reports on the remaining 36 patients who responded to the drug showed that remissions were of longer duration when maintenance therapy was employed. This group averaged 57 days.

Oncovin is administered intravenously at weekly intervals. The size of dose is determined by body weight. In children, remissions from acute leukemia have been induced with weekly doses of 0.05 to 0.15 mg. per Kg. of body weight.



DANGER OF ACCIDENTAL POISONING INCREASING

More children receive emergency medical treatment because they have been accidentally poisoned than for any other reason according to medical authorities.

Accidental poisoning has become an increasingly serious medical problem as the number of poisonous substances used in the home — such as deodorants, iodine, fingernail polish remover, insecticides, moth balls, some detergents and others — has rapidly increased because of continuing advances in organic and inorganic chemistry, manufacturing processes, and marketing and distribution.

A recent issue of Therapeutic Notes, published by Parke, Davis & Company, reports that "almost half of the cases (of accidental poisoning) are in children less than five years of age."

And, a survey conducted by the American Academy of Pediatrics showed that accidental poisonings were blamed for 51 per cent of all accidents reported by Academy members in private practice.

The greatest number of these cases happen in families living in small, over-crowded homes with inadequate storage areas, where children may easily reach sedatives, possibly harmful medicines, bleach and lye, turpentine and pesticides.

However, statistics show that more deaths result from breathing carbon monoxide (such as, the exhaust from automobiles or fumes from a gas or coal stove) than from any other form of chemical poisoning.

The medical journal points out that while most poisonings, which involve children happen accidentally, "in adults many of these deaths are intentional rather than accidental."

Medications most frequently involved in cases of fatal poisoning (in adults) are barbiturates, sedatives, and tranquilizers.

"Still high on the list of deadly substances are compounds of lead, arsenic and mercury as well as certain acids and alkalies used as cleansers."

Therapeutic Notes emphasizes that because of the alarming increase in cases of poisoning, efforts have been stepped up to help save the lives of more people who suffer from poisoning.

Among these have been the establishment of poison control centers in many U. S. cities.

The first formal poison control center began in Chicago, in 1953, and by March, 1961,

there were at least 466 centers officially recognized by the National Clearinghouse for Poison Control Centers.

Activities of the centers are coordinated by the National Clearinghouse for Poison Control Centers, an official agency of the Public Health Service of the Department of Health, Education and Welfare.

The Clearinghouse, established in 1957, is part of the accident prevention program of the Department of Health, Education and Welfare. It collects information on poisons from all sources and makes that data available to poison control centers.

Centers are of three types: First, is the information center remote from the place of treatment, staffed with trained personnel, and available to physicians and others on a 24-hour per day basis.

Such centers provide information and education only.

The second type provides both information and treatment, and is usually located in a hospital where physicians are available around the clock.

Therapeutic Notes states that "every hospital emergency room, however, can be designated properly as a treatment center, and these represent the third type of control center.

Another organization concerned with poisoning is the American Association of Poison Control Centers, formed in 1958.

This independent voluntary agency has developed standards of operation for poison control centers and is promoting research and education in the prevention and control of poisoning.

FDA STATEMENT ON ENOVID

Food and Drug Commissioner George P. Larrick has recently announced that it is the conclusion of FDA, based on a report by an advisory committee of medical experts and on other data, that the oral contraceptive Enovid should remain available for use on physician's prescription.

However, FDA has requested the manufacturer to change the labeling to advise physicians of certain contraindications and of an apparent hazard in women over 35. Principal contraindications for use of Enovid as a contraceptive are:

1. Certain cancers.
2. Liver disfunctions or diseases.
3. Patients with a history of thrombophlebitis or pulmonary embolism.

Enovid is only recommended for short term use (2-4 years). It is recommended primarily where pregnancy is contraindicated.

The advisory committee of medical experts found that there is not enough evidence to show whether there is a relationship between consumption of Enovid and the occurrence of certain circulatory disorders, principally thrombophlebitis and pulmonary embolism. Statistical evaluation indicates that there is an apparent hazard from the consumption of Enovid by women 35 years of age or over. FDA said this apparent hazard must be weighed by the physician against the demonstrated hazard of pregnancy in determining whether to administer the drug to women of that age group.

The Committee found need for additional studies regarding the possible effects of Enovid. Such studies are now underway and others will be undertaken.

THE SPRINGS OF GRATITUDE

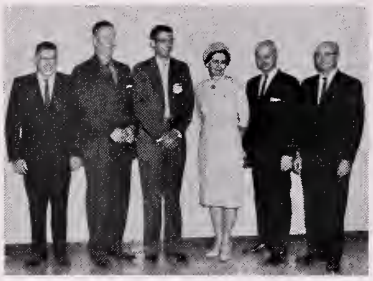
(Robins Reader)

Dr. Albert Schweitzer, about whom so much has been written, has shared with us his views on gratitude. He thinks we are too inclined to consider gratitude a scarce commodity, that there is much more of it around than we might suspect. He cites his own life as an example. A great many people helped him in his youth, but he seldom thanked them for it. Yet down in his heart he was sincerely grateful. He simply neglected to let those who inspired his gratitude know about it. It was years later before he came to realize the pleasure people get from receiving the expressions of gratitude they have earned.

Dr. Schweitzer urges us not to accept too readily what people say about the degree of ingratitude in our fellowmen. Often, he observed, it is shyness that keeps people silent. Somehow gracious expressions seem silly coming from them.

"A great deal of water is flowing underground which never comes up as a spring," he writes. "We must try to be the water which does find its way up. Each of us must become a spring at which men can quench their thirst for gratitude."

PHARMACEUTICAL NEWS



New officers of the South Dakota Pharmaceutical Association elected at the 77th annual convention in Pierre, June 25, are from left to right: Chan Shirley, Brookings, treasurer; Lloyd Wagner, Marion, 4th vice-president; Earle Crissman, Ipswich, 3rd vice-president; Mrs. Nina Lund, Rapid City, 2nd vice-president; Mel Holm, Redfield, 1st vice-president; and Wayne Shanholtz, Mitchell, president.

These officers will direct the activities of the 240 drug stores and 700 active pharmacists in South Dakota for the coming year.

EMERGENCY DRUG DEPOT ESTABLISHED AT RAPID CITY

An Emergency Drug Depot has been established at Rapid City through the efforts of the Rapid City Pharmaceutical Society. The Depot is housed in the Pennington County Health Building and the drugs stocked are available for use throughout the State.

Operating on a strictly non-profit basis, doctors who use the drugs are asked only to replace them or pay the replacement costs. Cooperating in this service are the State Highway Patrol and the National Guard. When drugs are requested, they are dispatched to the Highway Patrol unless the roads are impassable or the time element such that the National Guard helicopter would be needed to speed delivery.

The following drugs are presently being stocked:

Albumisol 5%
Antihemophilic Plasma
Antirabies Serum
BAL
Black Widow Spider Antivenin
Botulism Antitoxin
Cholera Vaccine
Cyanide Poison Kit
Fibrinogen
Gas Gangrene Antitoxin
Hypertussis
Modumate
Picrotoxin
Rattle Snake Antivenin
SKF Special Resins
Thrombin, Topical

STATE COLLEGE STAFF MEMBER ATTENDS NATIONAL MEETINGS

Dr. Kenneth Redman, professor and head of the department of pharmacognosy

at South Dakota State College attended three professional meetings at the University of North Carolina, Chapel Hill, during the month of July.

A charter member of the American Society of Pharmacognosy, he presented an illustrated lecture on "Production and Commerce of Vanilla" at the society's fourth annual meeting July 18-20.

He also attended sessions of the 64th annual meeting of the American Association of Colleges of Pharmacy, July 21-23, and a Teachers' Seminar on Pharmaceutical Education, July 23-26.

A South Dakota State College staff member since 1951, Redman recently accepted an invitation to join the section for the study of medicinal plants of the Federation Internationale Pharmaceutique.

DISTRICT BOARDS AND COLLEGES TO MEET

District V of the National Association of Boards of Pharmacy and the American Association of Colleges of Pharmacy will hold its annual meeting in Iowa City, Iowa, September 29-30. Represented at the meeting will be boards and colleges of pharmacy from a five state area consisting of Iowa, South Dakota, North Dakota, Nebraska and Minnesota.

District meetings of boards and colleges are held annually throughout the nation. Their purpose is the discussion of problems of individual and mutual interest.

NATIONAL SURVEY UNDERWAY

The U. S. Public Health Service Grant to the American Pharmaceutical Association for a national survey to evaluate the community pharmacy as a Health Education Center is officially underway.

A questionnaire was mailed on July 12 to some 8,000 pharmacies across the nation to assist National Analysts in making a national random sampling of the 360 pharmacies that will eventually be selected to participate in the national survey. The questionnaire asks for the number of pharmacists (including owners and partners) practicing on a full-time basis in the pharmacy; the number of non-pharmacist employees (including all sales people, but no clerical, delivery and cleaning staff) employed on a full-time basis in the pharmacy; and the percentage of dollar volume of prescription medication and related health items as compared with the total dollar sales volume of the entire pharmacy.

In the signed letter, A.Ph.A. Executive Director William S. Apple states, "The completion of this questionnaire in no way obligates the pharmacy to further participate in this program. However, prompt attention to the return of this questionnaire will show that pharmacists are interested in determining how they can better serve the public."

A.Ph.A MEETING DATES

The 111th Annual Meeting of the American Pharmaceutical Association, originally set for Philadelphia the week of May 3rd, 1964, will be held in New York City the week of August 2nd, 1964. The headquarters hotel will be the New York Hilton at Rockefeller Center.

The 1965 Annual Meeting will be held as scheduled in Detroit the week of March 28 - April 1, 1965. The 1966 Annual Meeting has not yet been scheduled.

STATE BOARD ISSUES LICENSES TO TWENTY PHARMACY GRADUATES

The South Dakota State Board of Pharmacy has issued Certificates of Registration to twenty pharmacy graduates who took the Board examinations June 4, 5, 6, 1963. There were no candidates for licensure by reciprocity.

The newly registered pharmacists are **Richard Alick** (3478), Sioux Falls; **Norman G. Berg** (3479), Marshall, Minn.; **Douglas Lyle Dempster** (3480), Brookings; **Lyle M. Glascock** (3481), Rapid City; **Marian Ruth Hansen** (3482), Morris, Minn.; **Allan Jerome Huether** (3483), Wessington Springs; **Duane Edwin Kallsen** (3484), Struble, Iowa; **Robert C. Lester** (3485), Rapid City; **Roger A. Loeb** (3486), Faulkton; **Thomas E. Maples** (3487), Sioux Falls; **Rolland H. Nelson** (3488), Lake Preston; **Sally Cottrell Schlepp** (3489), Aberdeen;

Martin R. Shuey (3490), Chamberlain; **Grant Allen Sperl** (3491), Burke; **Robert D. Thompson** (3492), Brookings; **Warren Neil Verdeck** (3493), Marshall, Minn.; **John J. Vossler, Jr.** (3494), Sioux Falls; **Marlene M. Wallace** (3495), Britton; **Robert D. Wik** (3496), Faulkton; and **Robert E. Nelson** (3497), Garretson.

The examinations were conducted by Board members **Ted Hustead,** Wall; **Roger F. Eastman,** Platte; and **T. K. Haggar,** Watertown. Assisting them were **Bliss Wilson,** Pierre; **Harry Lee,** Alcester; and **Harold Schuler,** Pierre.

ACA PROPOSES STANDARDIZATION OF DRUG CATALOGS

The Industrial Relations Committee of the American College of Apothecaries has submitted recommendations to pharmaceutical manufacturers for standardizing product catalogs and revisions, with the aim of making the catalogs more useful to the practicing pharmacist.

The recommendations include selection of a uniform page size and the arrangement of all catalogs in three sections: cost or price listing; product information; and company policies. The committee proposes the use of the following uniform symbols to mark specific revisions:

(A) to indicate price advance;

(D) to indicate price decline;

(X) to indicate product deletion (date of deletion should be included and this information should be carried forward through two catalog revisions);

(NP) to indicate a new product, along with date of introduction; Rx to note that prescription is required under Federal law; and A, B, X or M to indicate Narcotic category where applicable.

ACA President Lee E. Eiler urged industry-wide adoption of these catalog recommendations. He also called for increased attention by manufacturers to their "returned goods" policies. These policies are variable through the industry, ranging from excellent to poor, with some being vague and fluctuating. "A situation like this can create misunderstanding which weakens good intraprofessional relationships," Eiler noted.

Chairman of the ACA Industrial Relations Committee which was responsible for drafting of the recommendations is Leroy A. Weidle, Jr., St. Louis, Missouri.

FDA PUBLISHES LISTINGS OF NEW DRUGS

The Food and Drug Administration has begun publication of listings of new drugs approved as safe and effective under the Federal Food, Drug, and Cosmetic Act as amended by the new Kefauver-Harris law.

The first public notice of new drug approvals, appearing in the Federal Register of August 6, covers applications approved during the period from enactment of the Kefauver-Harris law, October 10, 1962, to May 31, 1963, inclusive. Subsequent lists will be published regularly.

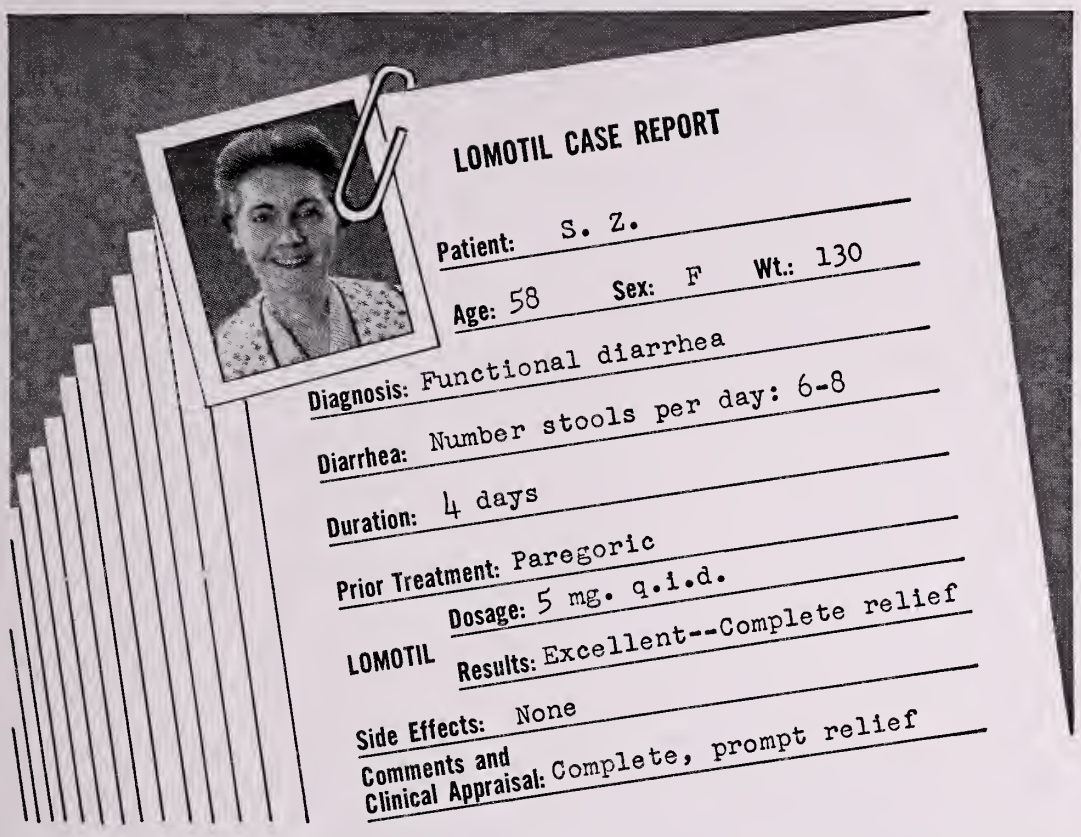
The listings are for the information of the medical and dental professions, veterinarians, and pharmacists, but are not intended to advise the professions or the public about the use of the drugs.

FDA pointed out that the drugs listed may include some which are now being approved for distribution by the applicants, but which have previously been marketed by other firms.

Reprints of future new drug listings will be sent to interested persons upon written request to the Division of Public Information, Food and Drug Administration, Washington 25, D. C.

National Pharmacy Week

OCTOBER 6 - 12



To control diarrhea...promptly

prescribe LOMOTIL® promptly

Each tablet and each 5 cc. of liquid contains: 2.5 mg. of diphenoxylate hydrochloride (Warning: may be habit forming) and 0.025 mg. of atropine sulfate

The direct, well-localized activity of Lomotil relieves spasm and cramping and provides prompt symptomatic control of virtually all diarrheas.

Numerous investigators have remarked on the effectiveness of Lomotil in patients with diarrhea uncontrolled by other agents.

Weingarten and his associates[1] found it "an excellent drug . . . efficacious where other drugs have failed. . . ."

Hock[2] obtained "results superior to prior medications in 68.3 per cent of 41 patients."

Since Lomotil controls diarrhea so consistently, it is only rational to prescribe Lomotil *before* other agents have a chance to prove inadequate. To control diarrhea promptly, prescribe Lomotil promptly.

Lomotil is an exempt narcotic, its abuse liability being comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of the latter is added to discourage deliberate overdosage.

1. Weingarten, B.; Weiss, J., and Siman, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961. 2. Hack, C. W.: Relief of Diarrhea with Diphenoxylate Hydrochloride (Lomotil), J. Med. Ass. Georgia 50:485-488 (Oct.) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine



Get your low-back patient back to work in days instead of weeks

You can expect rapid results from 'Soma' (carisoprodol)—because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 41 days without it. (J.A.M.A., April, 1960.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories
Cranbury, New Jersey



Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced.[1-2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality."[1] *Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients.* Rautrax-N is effective in mild,[3] moderate,[3,4] or severe hypertension.[4,5]

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycosuria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. *Rautrax-N Modified*—50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

SQUIBB
Squibb Quality
—the Priceless Ingredient
SQUIBB DIVISION Olin

RAUTRAX®-N RAUWOLFIA SERPENTINA WHOLE ROOT (50 MG.), BENDROFLUMETHIAZIDE (4 MG.) WITH POTASSIUM CHLORIDE (400 MG.), SQUIBB







all things considered...the decision is for

in otitis media, having weighed the classical considerations basic to management, physicians often choose DECLOMYCIN demethylchlortetracycline for broad-spectrum antibiotic therapy. DECLOMYCIN demethylchlortetracycline produces activity levels higher than do other tetracyclines... at lower dosage...and maintains them without significant fluctuation.

Activity is prolonged 24 to 48 hours after the last









DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE *syrup*

dose, thus helps protect against relapse—an "extra dimension" in broad-spectrum control.

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction.

Syrup, 75 mg. demethylchlortetracycline/5 cc. and *Pediatric Drops*, 60 mg./cc.

Average Daily Dosage—Infants and Children: 3 to 6 mg. per lb. body weight, in 2 or 4 doses.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

6568-3

Lederle

Fairmont 2% Fortified Skim Milk

REMARKABLE FRESH MILK PRODUCT FOR YOUR PATIENTS

When you recommend a substitute for whole milk in patients' diets — in order to minimize fat intake — think of Fairmont 2% Fortified Skim Milk. The dairy industry has met the demand for skim milk for years, but we believe that many people, who had been accustomed to the richer flavor of regular homogenized milk, were not satisfied. To fill this gap, we have replaced almost *one-half* of the butterfat with additional non-fat milk solids to make one great milk for the whole family that tastes rich but saves on fat intake. Perhaps of most interest to the medical profession is the fact that the milk solids we've added serve to boost the intake of milk protein and natural minerals.

The result is a milk which we believe you will find remarkable. This chart tells the story:

COMPARISON OF NUTRIENTS IN REGULAR VITAMIN D MILK, FORTIFIED SKIM MILK, AND 2% FORTIFIED SKIM MILK

	Regular Vitamin D Milk	Fortified Skim Milk	Fairmont 2% Fortified Skim Milk*	
			Range	Average
Calories**	156-160	80-84	145-150	148
Fat (%)	3.3-3.5	0.1	2.0	2.0
Protein (%)	3.1-3.3	3.2-3.4	3.9-4.2	4.0
Carbohydrate (%)	4.3-4.6	4.6-4.8	5.6-6.0	5.8
Milk Solids Not Fat (%)	8.3-8.7	8.6-8.9	10.6-10.9	10.7
Total Solids (%)	11.6-11.9	8.7-9.0	12.6-12.9	12.7
Calcium** (mg)	286-290	296-300	350-355	352
Phosphorus** (mg)	212-216	220-224	264-265	266
Vitamin A. (I.U.)***	142-148	2000	2000	2000
Vitamin D. (I.U.)***	400	400	400	400
Thiamine** (mg)	.10	.10	.13	.13
Riboflavin** (mg)	.41	.41	.53	.53
Niacin** (mg)	.20	.22	.25	.25

*Basis 2% B.F. — 2% SNF added to Skim with range in solids of 8.6 — 8.9% Nutrient Materials per Average Serving (8 Fluid oz. or ½ pt.)

**Per average serving (8 Fluid Ounces)

***I.U. — International Units per Qt.

— Source: Milk Industry Foundation Handbook

You'll notice that the only vitamins added are:

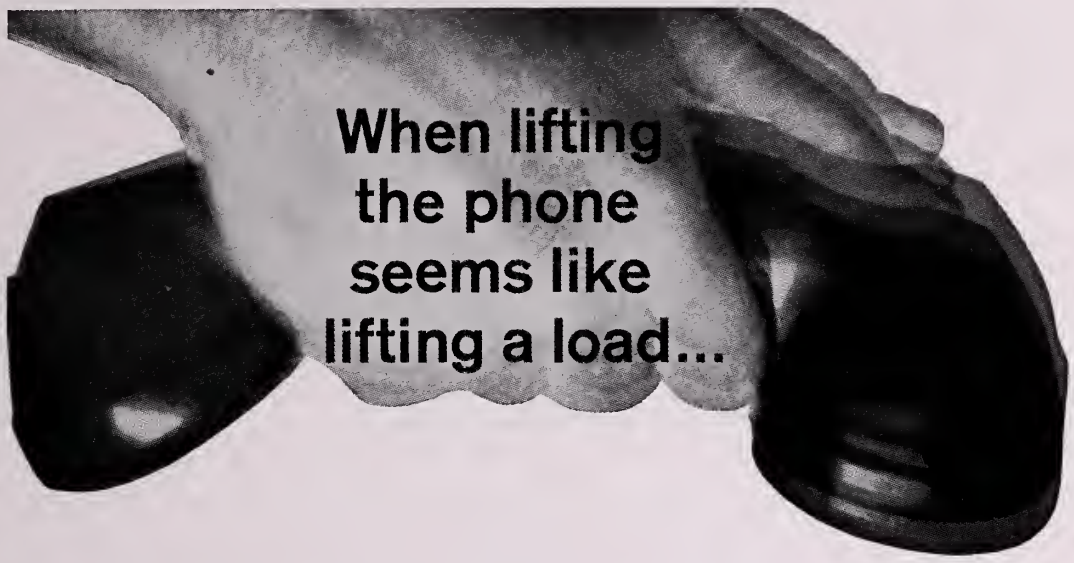
1. Vitamin D in the usual amount added in Vitamin D milk.
2. Vitamin A in amounts adequate for children.

The rest of the added vitamins and minerals come entirely from the additional skim milk solids, not fat.

If you are not already familiar with Fairmont 2%, we would be pleased to have you try it — notice its consistency, its palatability. If you would like additional information, we will gladly supply it. Just call your local Fairmont branch office, or write Fairmont Foods Company, 3201 Farnam Street, Omaha, Nebraska.

FAIRMONT

is finer . . . naturally



in chronic bronchitis and emphysema

ISUPREL® BRAND OF ISOPROTERENOL hydrochloride hydrochloride

MISTOMETER® Q.I.D.

ISUPREL (isoproterenol/Winthrop) "...can increase breathing efficiency in pulmonary emphysema."[1] The patient with chronic obstructive pulmonary disease "...should use the bronchodilator four times daily whether or not he experiences episodes of bronchospasm."[2]

Use of the Mistometer eases breathing by relaxing bronchospasm, and aiding productive cough. "Of the aerosol bronchodilators, ISUPREL (isoproterenol/Winthrop) seems to be the best...."[3] Conscientious use q.i.d. improves vital capacity and exercise tolerance.

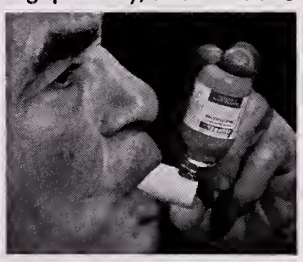
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With use of ISUPREL (isoproterenol/Winthrop), occasionally tachycardia, palpitation, nervousness, nausea and vomiting or headache may occur, especially with excessive dosage. Adjust dosage carefully in patients with hyperthyroidism, acute coronary disease, cardiac asthma or limited cardiac reserve, and in persons sensitive to sympathomimetic amines.

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1. Reeves, J. E.: *M. Times* 90:512, May, 1962. 2. Williams, M. H., Jr.: *M. Sc.* 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: *J. Kansas M. Soc.* 56:486, Sept., 1955.

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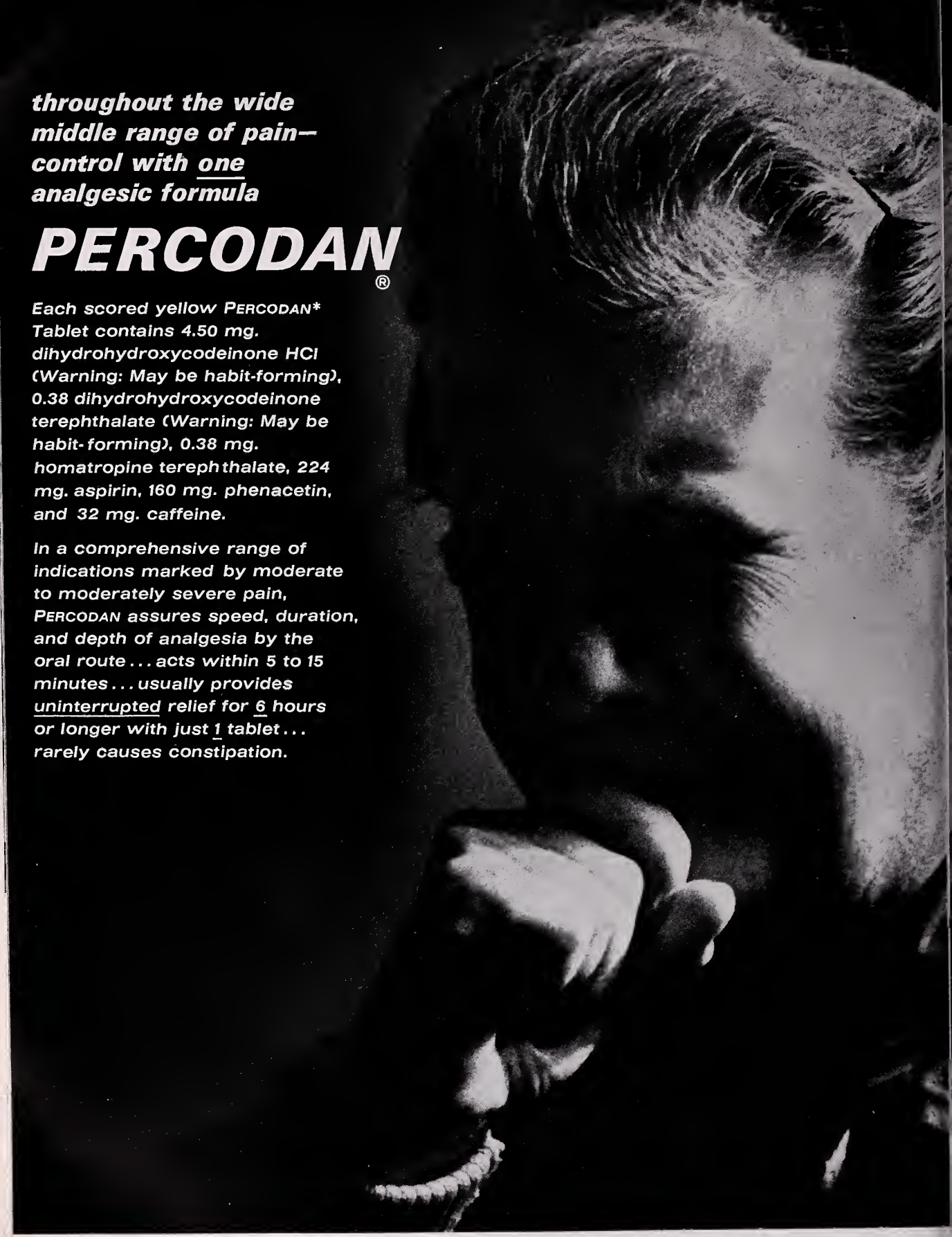
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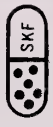
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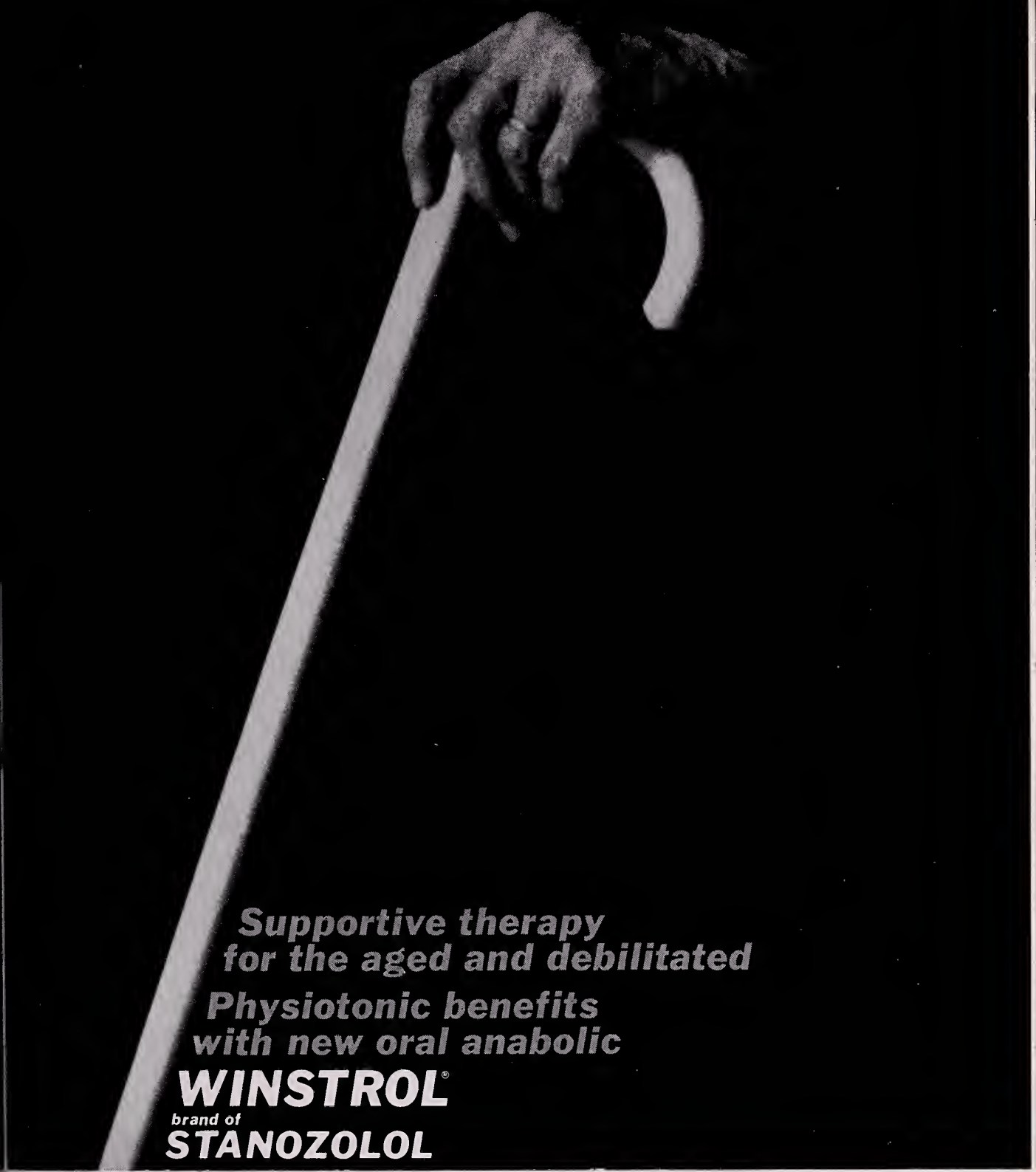
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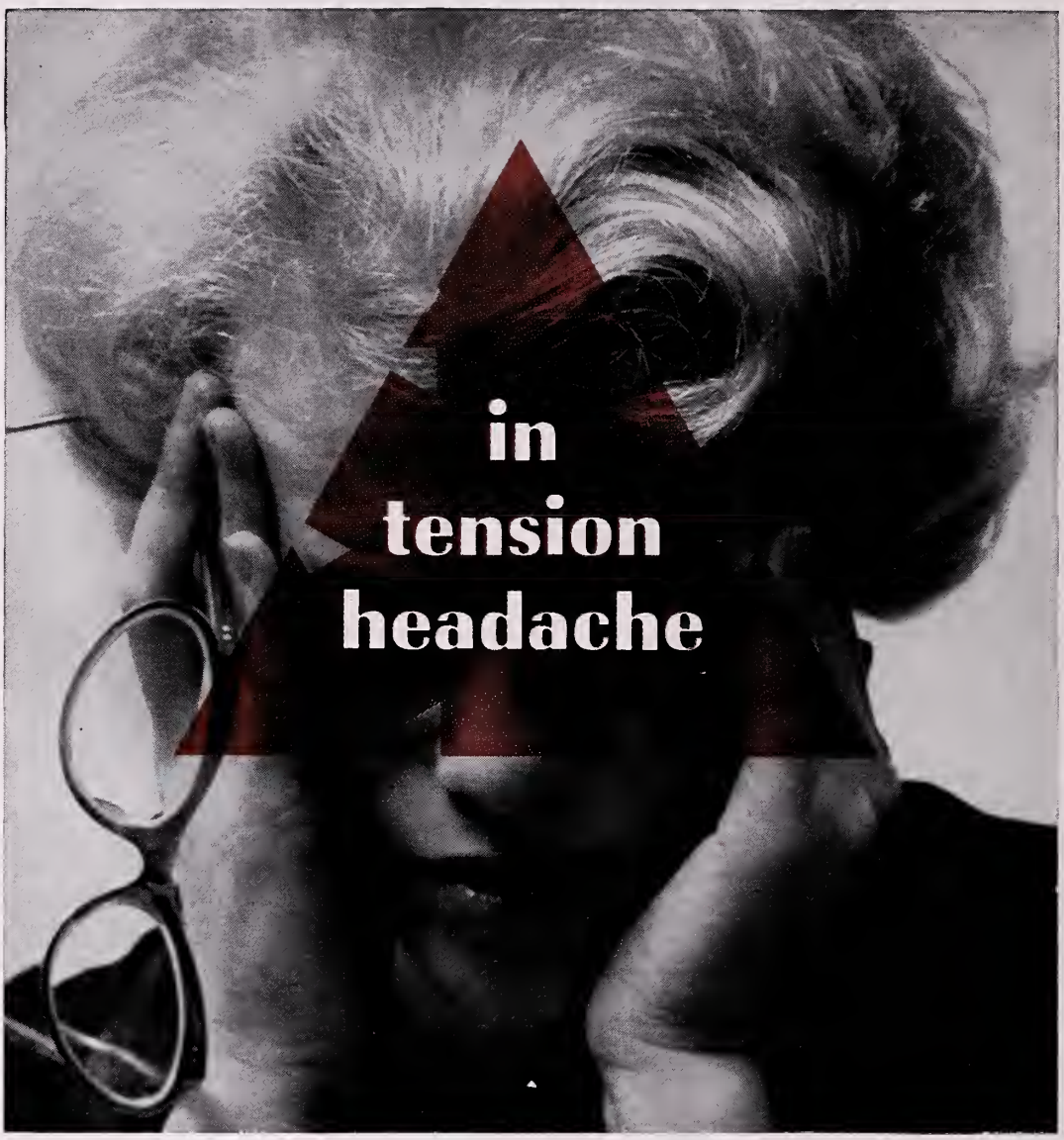
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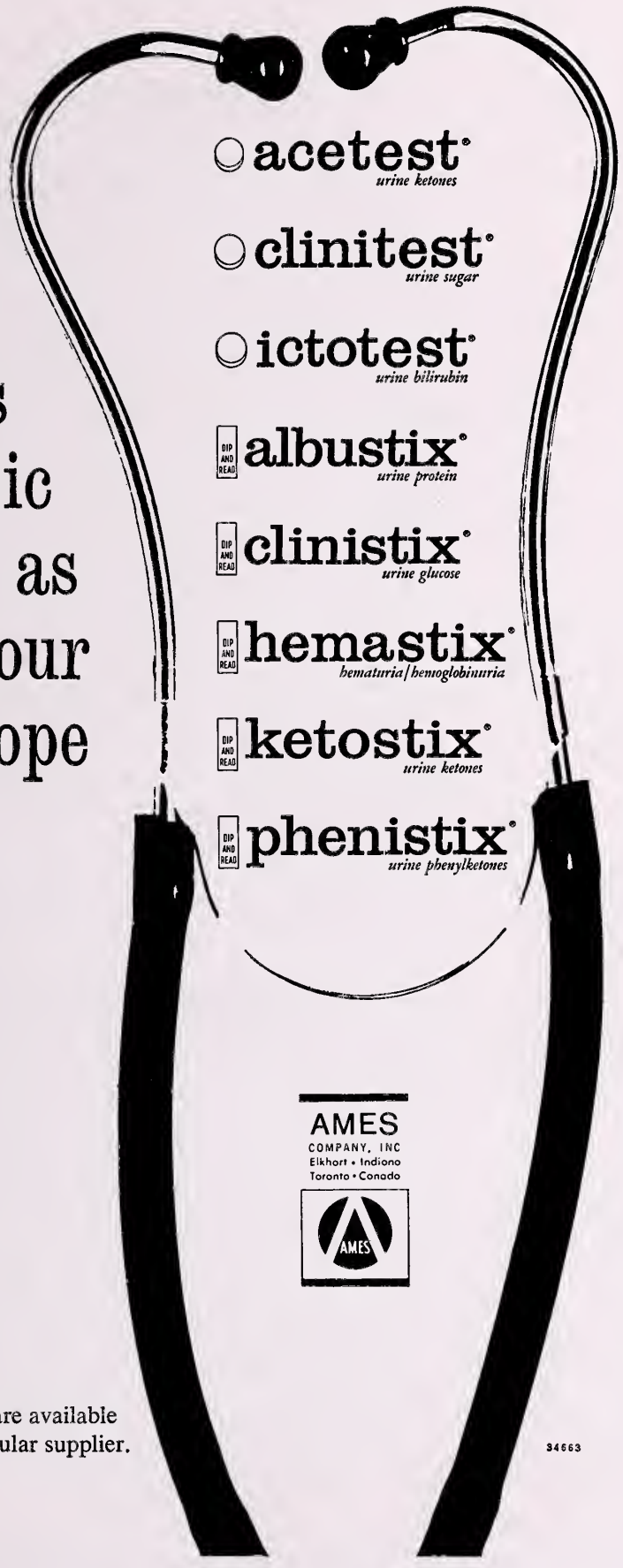
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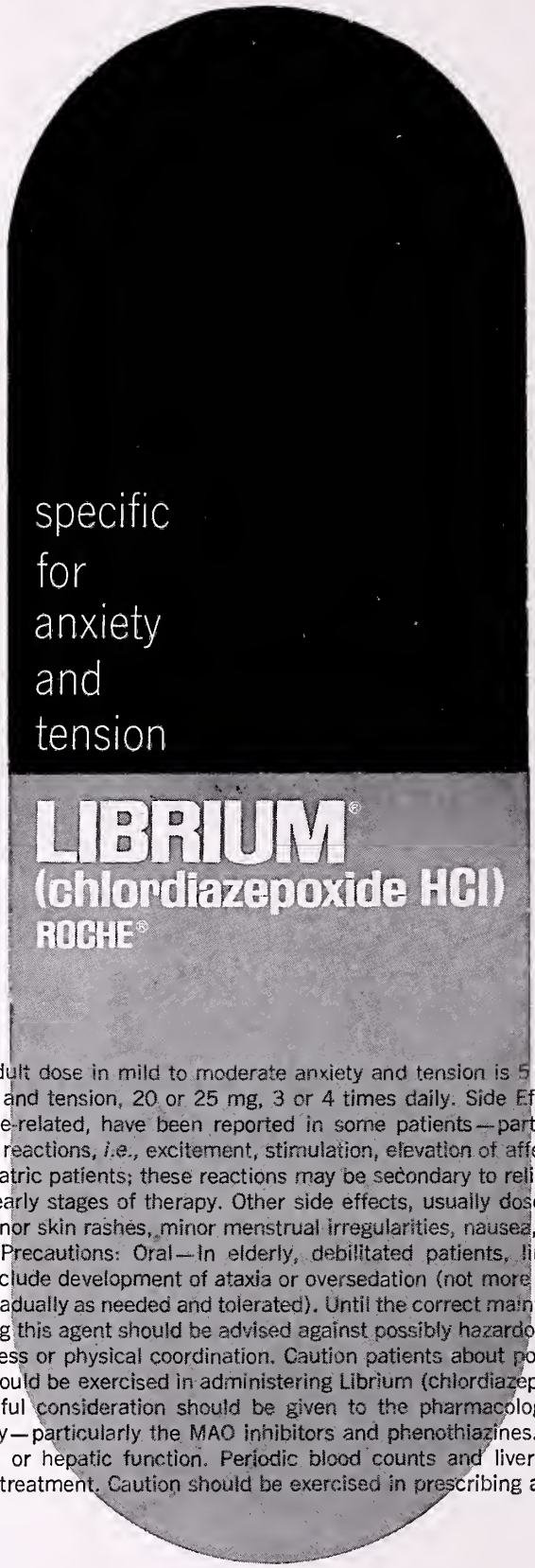
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MEDICINE and PHARMACY

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REFERENCES: (1) Hammill, J. F.: J. Chron. Dis. 8:448, 1958. (2) Roseman, E.: Neurology 11:912, 1961. (3) Bray, P. F.: Pediatrics 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: M. Clin. North America 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) Ibid.: Postgrad. Med. 20:584, 1956. (8) Merritt, H. H.: Brit. M. J. 1:666, 1958. (9) Carter, C. H.: Arch. Neurol & Psychiat. 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

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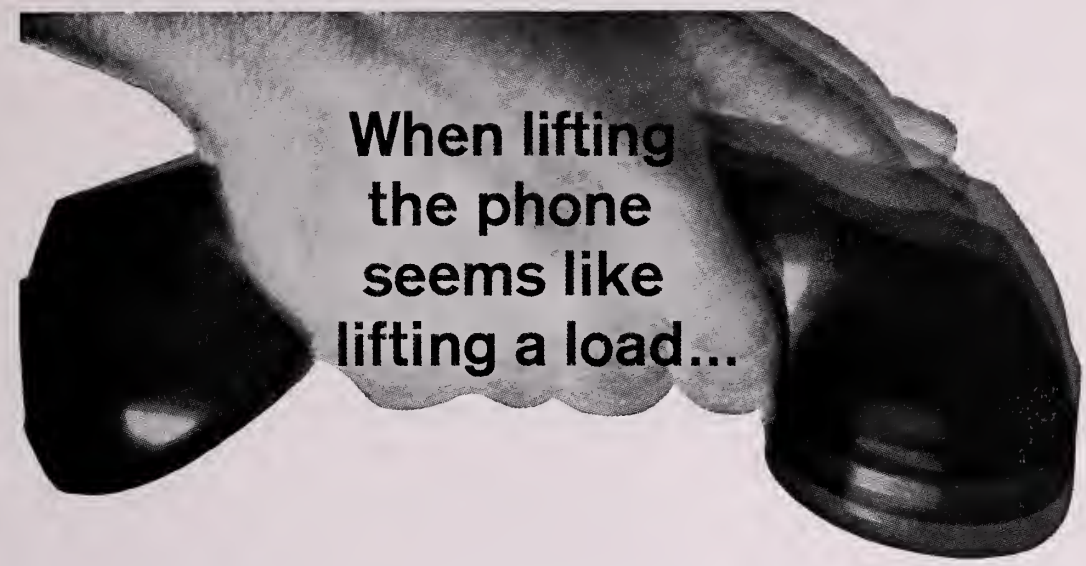
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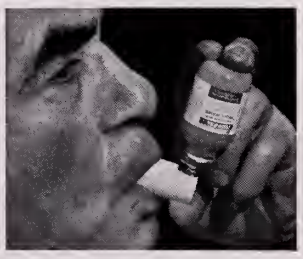
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1. Reeves, J. E.: *M. Times* 90:512, May, 1962. 2. Williams, M. H., Jr.: *M. Sc.* 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: *J. Kansas M. Soc.* 56:486, Sept., 1955.

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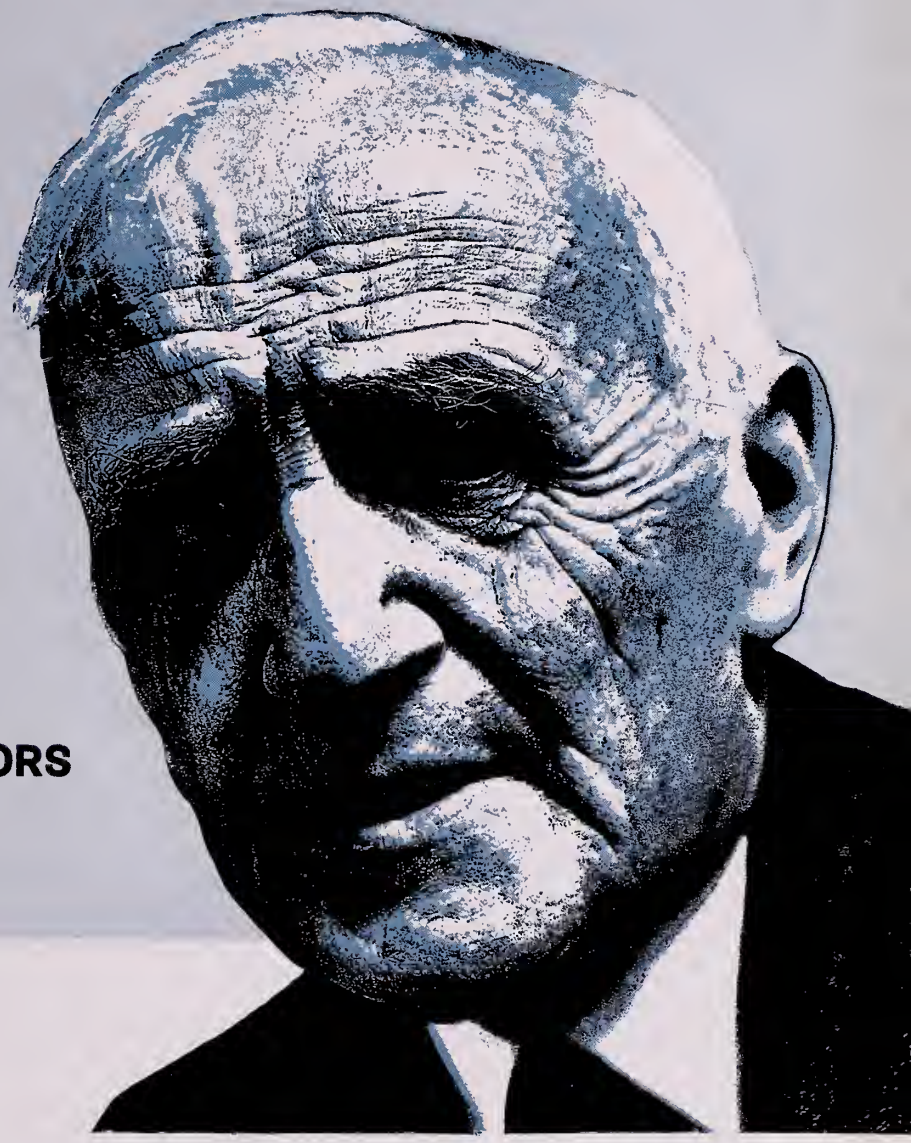
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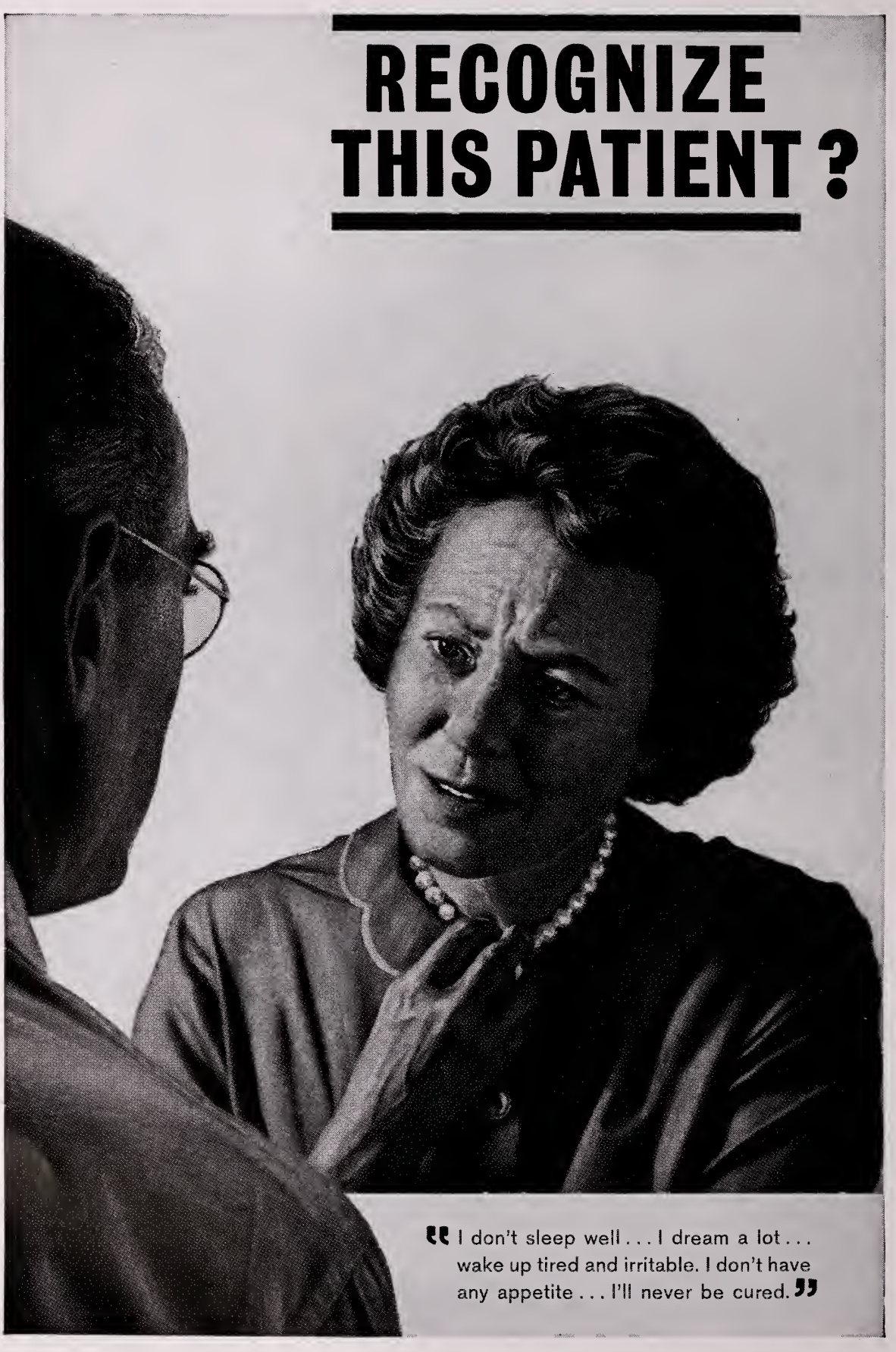
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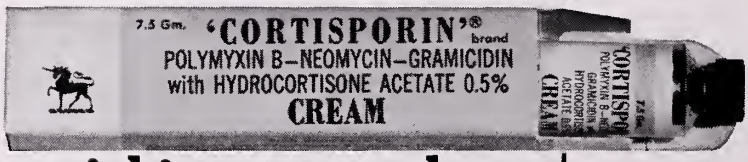
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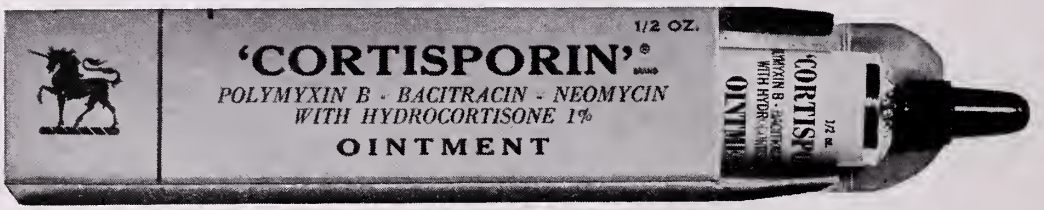
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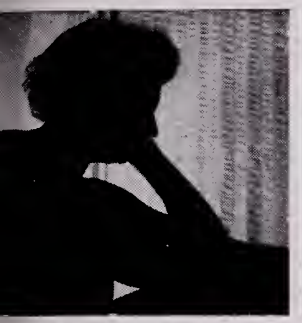
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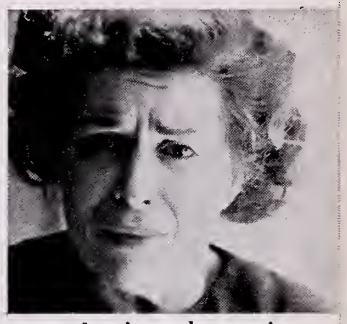
ıe girl with dermatosis



Tension headache



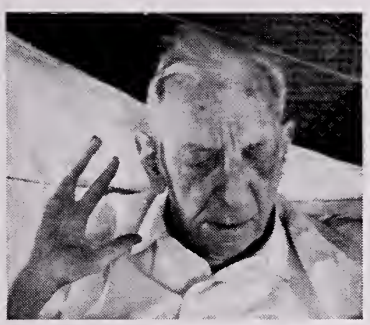
The woman in menopause



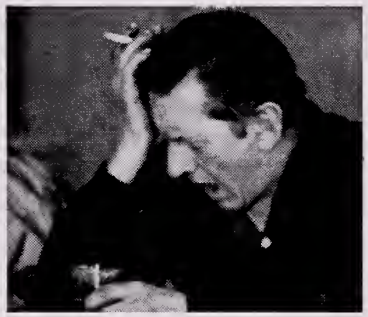
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*Schwartz, I. R.:
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Fluid and Electrolyte Therapy for Children*

By

Donal Dunphy, M.D.**

Iowa City, Iowa

It is not pertinent in this discussion to review the various measures by which fluid and electrolyte homeostasis is maintained by the body or the various mechanisms by means of which the body attempts to adjust for alterations in hydrogen ion concentration. It is sufficient here to indicate that cellular metabolism results in a constant production of an acid load, and homeostasis must be maintained by the transportation and removal of this load. This is achieved by: (1) the Intracellular buffering system; (2) Extracellular buffering; (3) Cellular-extracellular Exchange Mechanisms; (4) Renal Hydrogen ion control; (5) Respiratory exchange. A thorough understanding of these various mechanisms will allow the clinician to approach the clinical problems of dehydration and acidosis with a sound physiological basis.

Children, and particularly, infants are vulnerable to fluid loss resulting in the rapid development of dehydration and acidosis. It is the intent here to outline a program of therapy which is effective in the vast majority of clinical situations in correcting dehydration. However, it is imperative if the clinician expects to cope with the exception that he have a basic understanding of the physiological mechanisms involved.

Any fluid program should have the following components: water, electrolytes and calories. It is desirable in infants and children to supply calories for the prevention or amelioration of ketosis. Children, and particularly, infants are susceptible to this derangement of metabolism. This is presumably due

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* Presented in part at the Sioux Valley Medical Association in February 1963.

to their limited glycogen stores. Furthermore, it is also possible to decrease endogenous protein metabolism by supplying calories.

Water is essential to meet maintenance needs as well as to replace deficits. In the presence of decreased available water, renal excretion of solutes is impaired and glomerular filtration rate falls. This results in the accumulation of the acid end products of cellular metabolism and nitrogenous wastes.

The need for electrolytes is as obvious as the need for water in a parenteral fluid program. Electrolytes are essential for the maintenance of osmotic equilibrium, electrical neutrality and a normal hydrogen ion concentration. Electrolytes are lost with insensible water loss and urine is never salt free. The kidney can conserve electrolytes but can never correct for an electrolyte deficiency. In disease states the renal concentrating mechanism seems to be less efficient and loss of electrolytes appears to increase due in part to increased catabolism. Certain diseases result in marked electrolyte loss. Diabetes mellitus for example may produce great losses of water and electrolytes in the urine due to the osmotic diuresis resulting from high concentration of sugar. The kidney is unable in such circumstances to conserve salt and water. An ileostomy or a similar clinical problem may also lead to marked electrolyte losses.

The amount of fluid to be given either in maintenance or in replacement may be calculated on the basis of weight or surface area or on the basis of caloric expenditure. Surface area is a useful clinical means of calculating fluids since most body requirements happen to be approximately proportional to body surface. This fact coupled with a knowledge of the electrolyte losses in disease allows the development of a clinically effective program provided the rate of administration does not exceed physiologically tolerable rates. Table I gives the relationship between weight in pounds and surface area.

TABLE I
BODY WEIGHT IN POUNDS, BODY SURFACE AREA

Pounds	Sq. meter (M^2)	Pounds	Sq. meter (M^2)
5	0.14	60	1.0
10	0.25	80	1.2
20	0.42	100	1.3
40	0.72	120	1.5

The average electrolyte losses in mEq per liter of stool water in children with diarrhea reported by a variety of authors is surprisingly similar as depicted in Table II. The average losses of electrolytes in ileostomies (recent) are also presented for comparison. The electrolyte concentration in small bowel fluid is considerably higher than in diarrheal stools. While the average losses are very similar the ranges have been great.

TABLE II
Average Electrolyte Losses mEq/Liter of Water Loss

	Na	K	Cl	Ref.
Diarrhea	41	29	41	(1)
	59	27	51	(2)
	64	44	55	(3)
	65	50	45	(4)
Ileostomy	129	11	116	(5)

The range of losses of the various electrolytes in diarrheal stools reported by Finberg[4] et al., were so great that they concluded that "no preconceived average solution can be assumed to replace stool losses accurately in a majority of infants." Nevertheless, an electrolyte solution, the composition of which approximates the average losses of electrolytes per liter of water loss, has proved highly effective.[6, 7] The reason this is so in view of the variation in losses between patients is that it is possible for children to cure themselves provided that water, sugar, sodium, potassium, and chloride are given in amounts and at rates which allow the patient's homeostatic mechanism to accept or reject each of the administered substances in keeping with individual needs. Hence, it is possible to design a parenteral fluid program using solutions which maintain this relationship between the average amounts of electrolytes per liter of water lost from the body. A parenteral fluid plan based on this relationship has a major advantage; that is in meeting the water needs of the patient one automatically provides needed electrolytes.

The calculation of water needs or in essence, the determination of the amount of parenteral fluid to be given can be determined by reference to surface area. It was pointed out earlier that water or fluid requirements happen to bear a relationship to surface area. This is a safe and simple means of determining water needs. The water requirements per square meter of surface area for a variety of clinical conditions are indicated in Table III.

TABLE III
FLUID & ELECTROLYTE REQUIREMENTS
mL & mEq/m^2/24 hrs

	Maintenance	Dehydration	Diabetic	Small Bowel
Water	1500	3000	4000	3000
Na	30 mEq	60	60	122
Cl	22 mEq	50	50	104
K	15 mEq	25	25	35
Cals. (glucose)	600	1200	1600	1200

The calories given by employing 10% glucose are indicated. The electrolyte content which has been found to be satisfactory and effective in a variety of clinical states is depicted. The electrolyte composition is a reflection of the losses that occur in disease or are required for maintenance as indicated above. It can be readily seen that a limited number of solutions are effective in a wide variety of clinical states. Specifically, three are all that are needed to meet the need of the majority of patients.

An example will indicate the simplicity of calculating fluid and electrolyte needs:

> An infant weighing 10 lbs. (4.5 Kg.) has a surface area of 0.25 M^2, ie, ¼ of a square meter, would require the following fluid program depending on his clinical status.

TABLE IV
FLUID PROGRAM FOR A 10 POUND INFANT
(0.25 M^2/24 hrs.)

	Maintenance 1500 c.c./M^2	Dehydration 3000 c.c./M^2	Small Bowel 3000 c.c./M^2
Water	375 c.c.	750	750
Na	30 mEq	60	122
Cl	22 mEq	50	104
K	15 mEq	25	35
Cals. (glucose)	150	300	300

Sound clinical judgment coupled with an understanding of physiological mechanisms can not be replaced with a "cook book." Consideration of the patient based on clinical evaluation is the essential basis of therapy. Therapy is not directed toward the correction simply of a blood value of Na, CO_2 or K. The plan outlined is applicable as a general method but a note of caution is necessary. The program as outlined, to emphasize again, is dependent for its efficacy upon the ability of the kidney to select and retain electrolytes the body needs, and to conserve or reject water in order that homeostasis may be achieved or maintained.

At the time a patient first presents it is not always possible to be certain of the integrity of renal function, it is most important therefore, that this be determined prior to the administration of potassium containing solutions. It is usually possible to determine the ability of the kidney to form urine even in the severely dehydrated patient by administering a solution containing 50 mEq Na, 50 mEq Cl and 10% glucose. This is administered in the amount of 12% of the calculated total requirement for the first 24 hours of treatment. This amount is given in a relatively brief period of time, 45-60 minutes. In the vast majority of patients this will re-expand plasma volume and provide water and electrolytes permitting urine formation. At the completion of the administration of this initial volume of fluid (urine flow having been established) potassium containing solutions may be administered. Should urine flow not be established after completion of the hydrating solution, the composition of the fluid should remain the same, ie, 50 mEq Na, 50 mEq Cl in 10% glucose, the rate is slowed to provide the total calculated fluids in 24 hours and chemical analyses are imperative as the nature of the fluid program must be completely individualized. This requires laboratory support, careful clinical appraisal and accurate weight determinations.

The importance of renal function can be appreciated from the following:

> An infant weighing 4.5 Kg. (10 lbs.), dehydrated requires 3000 c.c./M^2 or 750 c.c. in the first 24 hours of replacement solution for correction.

This same infant when well would grow and thrive on the following formula:

TABLE V
INFANT FORMULA

	oz.	Cals.
Evaporated milk	10	400
Water	15	
Karo 2½ tbs.		150
	25 oz.	550 Cals.

It is apparent that the infant's total fluid intake on such a formula would be 25 oz. or 750 c.c., the identical quantity of fluid required to correct his dehydration. The reason that the same total daily fluid intake is able to correct an existing deficit is due to the integrity of the kidney and that the therapy solution has no obligatory osmollar load while the formula administered (milk) has. In this instance the infant would have approximately 160 mOsm to excrete in 24 hours. Assuming a reasonable value of renal concentration ie, that the kidney can concentrate

500 mOsm in a liter of urine, the infant in the example would require about 300 c.c. of urine to excrete the 160 mOsm resulting from the formula ingested. It is of interest to note that this amount, i.e., 300 c.c. would be close to the amount of the fluid lost in a fairly severe state of dehydration, ie., 10% of the infant's body weight.

The solutions employed in this program are designed to be given orally or intravenously. The administration of fluids such as these subcutaneously may seriously compromise a critically ill infant or child. Darrow and Yannet,[8] demonstrated years ago that electrolytes in extracellular water leave the circulation and enter the subcutaneous pool of administered fluid whenever the osmatic pressure of the salt content is lower in the pool. The composition of solutions given is compared to extracellular fluid in Table VI. It is evident that in all instances there would be a gradient favoring the migration of sodium into the subcutaneous pool. Water also would be drawn into the pool because of the glucose concentration. This loss of water and salt from the circulation is obviously hazardous.

TABLE VI
ELECTROLYTE CONCENTRATION IN VARIOUS FLUIDS

	Extracellular	Maint.	Dehydration	Small Bowel
Na	155 mEq	30	60	122
Cl	110 mEq	22	50	104
K	5 mEq	15	25	35

The initiation of fluid therapy is not dependent upon any laboratory analyses, although such analyses may be helpful in evaluating the clinical status of the child, they are not essential. The laboratory analyses which are helpful are as follows: (1) CO_2 content; (2) Sodium; (3) Chloride; (4) Urinalysis; (5) Potassium; (6) pH. These laboratory values while helpful are not mandatory in initiating therapy but are mandatory for adequate care of the complicated patient whose fluid program needs to be highly individualized. Cooke[9] has presented an excellent discussion of the essential contribution of the laboratory to therapy.

SUMMARY

A general plan of fluid therapy for a variety of clinical problems is presented. The effectiveness of the plan is dependent upon the homeostatic mechanisms of the individual patient, if these are seriously impaired then a highly individualized program must be considered.

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Urologic Problems in General Practice*

By

J. A. McFarlane, M.D.

L. E. Pierson, M.D.

Sioux City, Iowa

The largest number of calls that urologists receive from the practitioner for help in urologic problems which they encounter are those of catheterizing the obstructed male patient. The obstruction is usually due to intrinsic obstruction along the urinary passage or blood clots occurring in hematuria. The obstructions encountered in most instances are due to strictures developing anywhere along the urethra and bladder neck or obstructions associated with enlargement of the prostate gland. If one will obtain an adequate history from these individuals, a stricture can usually be diagnosed beforehand. Keep in mind that the patient who has had a transurethral prostatic resection may have a contracted bladder neck due to scar formation with a very marked stricture formation. The passwords of instrumentation of the male urethra are gentleness, adequate lubrication, and relaxation of the patient. In some instances of obstruction where it is impossible to pass instruments through the urethra, a greatly distended bladder in a very uncomfortable patient can be drained quickly by inserting a small gauge needle just above the pubis. Adequate drainage can be obtained until these patients can be transported to urologic help.

In dealing with the patient obstructed by blood clots a stiff rubber catheter should be used to allow aspiration of the clots. Whenever a catheter is passed, whether it be a retention or a straight catheter, it is wise to leave this in place as its removal may be followed by continued retention and inability to

* Read at the Sioux Valley Medical Association Annual Meeting, Sioux City, Iowa. February 21, 1963.

pass a catheter at the next call for your aid. Tape the straight catheter in place with adhesive tape.

In the management of hematuria, it is our feeling that symptomless hematuria in any age group and either sex should be investigated with x-rays and endoscopic studies. In those cases in which the hematuria is probably due to an infection, if the patient be a female and it is the first episode of hematuria with infection, a complete investigation is probably not necessary. In the male patient, however, it is wise to at least get an intravenous pyelogram. All hematuria due to trauma should be investigated as soon as the patient's condition permits. Hematospermia is usually due to prostatitis or seminal vesiculitis and frequently reassurance is all the treatment necessary for these apprehensive males.

Pyuria, in the female, is of little significance if the examined urine is a voided specimen. Any female patient with pyuria should have a catheterized specimen to adequately establish that the pus originates in the urinary tract. Male patients should have a two glass urinalysis to establish the source of the pyuria. The first glass indicates the source in the urethra or prostatic area, and the second glass indicates the pus originating from the bladder or upper urinary tract. In small girls one will frequently encounter the problem of recurrent urinary tract infections. A complete urologic investigation is done and nothing is found to establish the cause of this recurrent pyuria. Frequently in getting a history from the mother one can establish that these girls have not been adequately instructed in their personal hygiene as to wiping themselves following bowel activity. They will wipe the fecal contamination from the anus over the perineum and establish recurrent infections through this source. These children, having been treated many times with antibacterial agents clearing their infections satisfactorily and then having it recur, can be completely cured by the mothers training the children to wipe themselves following bowel movements from the anterior to the posterior aspect.

Enuresis presents a common problem to all. In the male, examination frequently determines urethral meatus stenosis as being the cause. A simple meatotomy will cure many of these patients. In the female, as previously elicited, recurrent infections due to poor personal hygiene may be the factor and the enuresis may be cured by the proper instruction of these children. In most cases of enuresis no urologic disease is found. A good many of them are due to emotional problems which is not in the realm of this discussion. However, many children have small capacitiy bladders as a cause of enuresis. Increasing the capacity of the bladder may help many of these patients. This can be done by instructing the parents and the child to hold the urine as long as possible in the daytime, having them urinate into a container in which the volume can be measured. They should attempt, from day to day, to increase the overall capacity. The use of anticholinergic drugs may be of help in some.

Many hypospadias problems are seen. It is very important for the physician and the parents to understand the problem that exists. In the severe hypospadias with the urethral meatus along the ventral surface of the penis and not near the glans, there is no question that these should be repaired. However, the patient who has the urethral meatus near the glans of the penis, actually in an adequate position for them to direct the urinary stream and to deposit the sperm at the cervix during intercourse, no repair is necessary. A good many of these, however, are accompanied with a chordee. This is a fibrous band on the ventral aspect of the penis, and as the child grows the fibrous band remains a constant size shortening the ventral aspect of the penis. This causes a ventral deviation of the penis. The ventral curve is more marked with an erection and this condition is incompatible with coitus later in life. The chordee should be corrected, and in so doing this usually causes the urethral meatus to become more proximal in position on the ventral surface of the penis necessitating a urethroplasty later. By two to three years of age it is known whether these children will have a chordee and it is recommended that the repair be started early in life, usually at two to three years of age. The importance of not circumcising these children cannot be overemphasized because the redundant prepuce is necessary in the repair of these defects.

Since the generalist is usually the first to encounter the problem of intersex, a brief discussion is in order. If there is doubt as to the sex of the child, one should not attempt to establish the sex without adequate evaluation from the standpoint of hormonal studies, sex chromosome studies, and, if necessary, surgical exploration. To establish the sex of the child without proper evaluation may lead to emotional trauma later in life.

Problems arising during urologic examinations bring to mind the plea for doing rectal examinations on all men over 50 years of age. By this means, many early carcinomas of the prostate can be detected and treatment offered to these individuals as a curative procedure rather than purely a palliative measure. One should also encourage the self examination of younger males to attempt early detection of tumors of the testicle. It has been emphasized to all of us that early cancer detection in the female is possible by encouraging self examination of the breast in women, but one very seldom hears the encouragement of self examination in the male. In disease of the testis, differentiation of inflammation, hydrocele, and tumor may be quite difficult. Epididymitis and hydroceles mask testicular tumors quite frequently and patients present themselves often with epididymitis or hydrocele as the first symptom of the tumor. Aspiration of the hydrocele, thus making the testicular parenchyma palpable, is important. If an epididymitis does not respond adequately to treatment, exploration should be considered.

In torsion of the testicle or spermatic cord early operation is essential. Since early operation is necessary to salvage a testicle which is the site of torsion, generalists frequently will be the ones called upon to operate. Keep in mind that the opposite testicle should be fixed at the same time. The congenital defect of testicular mobility is bilateral and later the opposite testicle may become the site of torsion.

Those of you who do x-rays in your offices frequently do intravenous pyelograms. This procedure is not without danger; the biggest danger being reactions to the radiographic media. Up to 1961 there were 156 deaths reported due to reactions to media used in excretory urography. This was a rate of 1 death in 150,000 examinations. Obtain a good history regarding allergies. Give a test dose of media, either introdermally or the injection of 1 cc. intravenously and waiting several minutes. One may use antihistamines mixed with the radiographic media, and of the utmost importance is having available an emergency setup for any reactions that do occur. One should have emergency measures immediately available as time is of the essence in treating some of the reactions which occur.

There is a parting remark I want to leave with you regarding x-rays. It is essential that you get a plain scout film or KUB before injecting the x-ray media as many urinary stones have been overlooked because of the absence of the plain film preliminary to the intravenous pyelogram.

Treatment of urinary tract infections can present many problems. Approximately three-fourths of urinary infections encountered are due to the coli aerogenes group and these will usually respond to Furadantin or Tetracycline quite well. If available, one should obtain culture and sensitivity studies. While awaiting the results of these, the empirical use of Furadantin or one of the Sulfas is encouraged. For long term therapy of chronic urinary tract infections, Furadantin, Sulfa drugs, and Mandelamine are favorites. In any recurrent urinary tract infection or continued non-responsive infection, encourage your patients to undergo urologic investigation.

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HOSPITAL ACCREDITATION — A BOON OR A MENACE?

The hospitals throughout the United States which desire to conduct internships, nurses schools, X-Ray technician training programs or other educational activities must be inspected every three years for accreditation. Liability insurance rates and acceptability for many insurance programs are also linked to successful accreditation. Evaluation and therefrom development of measures to help assure uniformity and high quality care of patients in hospitals is the goal of the Joint Committee for Accreditation in making the periodic inspections. Recently this tri-annual visit was made in South Dakota. If the events which occurred in one city of this state and the announcements of the proposed intentions of the Joint Committee are at all indicative of the trends, the physicians of the United States may look for much more stringent control of the hospitals and the privileges of the physicians who staff them. Although at the present time the philosophies and rulings of the Joint Commission pertain only to hospitals which seek accreditation, it is conceivable that the proposals for control could eventually apply to all hospitals.

Acceptable records, which includes "complete records" was announced to be the primary consideration upon which a major portion of the decision for accreditation rested. Although this could be a valuable clue as to the activity of the hospital and the staff, it is to be wondered if it should be the major deciding factor upon which a hospital is judged.

Other "recommended" policies of the examiners foretell serious limitations upon the medical staffs in the care of patients. It was repeatedly emphasized by the examiner who inspected the McKennan and Sioux Valley Hospitals in Sioux Falls, that the hospitals would have to make their own rules and regulations, but if these did not meet with the approval of the Joint Commission, the hospitals could not be accredited. It was announced by the examiner that not only would the hospitals be expected to examine the credentials of all who come onto their staffs in the future but all who are now on the staffs, and document in explicit terms for each, his medical, surgical, obstetrical and other hospital privileges. No grandfather clause would be acceptable in this determination of qualifications for privileges of the staff members. Although there is no unanimity of opinion as to what constitutes "major" and "minor" surgery, the hospital would be expected to spell out in no uncertain terms for each person what he could and what he could not do. If carried to the ultimate degree implied, this could seriously hinder many present and future practitioners in their care of patients. Such strict regulation of hospital staff activities might be feasible in a large city hospital which had a highly specialized staff but such regulations could hardly apply in a rural area where the general practitioner far outnumbers the specialist.

High hospital procedural standards and first class medical care for all are the desire of the staffs in the Sioux Falls hospitals.

However, the opinion was left with members of the hospitals' governing boards who met with the Joint Committee examiner that each physician must be considered an ignorant, poorly trained yokel until proved otherwise; that the hospital privileges in the future will be dictated by the Joint Committee, not by the local hospital's medical staff. The reason for this suspicious attitude was explained to those who questioned the J. C. examiner by referral to the high incidence of malpractice suits which are being seen in this country. If such a fear and such reasoning are allowed to perpetuate themselves to the extent that they are a major factor influencing the J. C. decision for accreditation, the free practice of medicine as it now exists may soon be a thing of the past.

Although the majority of the hospital staffs in the state of South Dakota will not be affected by these philosophies — now — it would behoove the physicians to become aware of, to investigate and to voice their opinions in the matter of hospital accreditation — soon.

ARE VERBAL Rxs TO A PATIENT — ADVISABLE?

By Irving Rubin, Ph.G., Editor
American Professional Pharmacist

It's 9 p.m. A physician's phone rings. It is Mrs. Jones, his patient. She tells him that she has a cough and that her temperature is normal. Her request: "Can you tell me what medicine I can take now, doctor? I'll probably see you tomorrow."

This situation — and many others like it — brings up this question: Should the physician give drug information verbally to the patient?

A just-completed national survey — conducted among pharmacists by **American Professional Pharmacist** magazine — points clearly to the following answer:

"In the interest of the patient's health and safety, the physician should write prescription orders—or phone them to a pharmacist."

More significant than the answer itself are the reasons for the answer. The study clearly shows that there are at least 6 specific reasons why verbal prescriptions — given directly to the patient — are generally not advisable:

Reason No. 1: With respect to verbal drug information, one of the problems encountered is **sound-alike** names of drugs. For example, when the patient is given the name of a drug, the patient too often misspells or mispronounces it — when relaying it. As a result, the patient can actually take the wrong medicine . . . or, more frequently, not obtain it at all, because the pharmacist cannot interpret the request.

Reason No. 2: Drugs are available in several forms and strengths. Although the patient may have the correct name of the drug, she may not remember the form or the strength. As a result — because she is too embarrassed to phone the physician again — the patient may not even obtain the medication.

Reason No. 3: Very often, a patient will forget the verbal dosage a physician prescribed for her. She will not remember, for example, whether she should take the medicine "before meals" or "after meals" . . . or whether she should take it every 3 hours or 3 times a day.

Reason No. 4: In cases where the patient correctly recorded or remembered the name of the drug, it might turn out to be an "Rx only" drug . . . and the pharmacist is unable to sell it without an Rx. The patient may then become angry at the physician and the pharmacist — for the delay and the inconvenience.

Reason No. 5: When the patient knows the name of a drug that was prescribed for her, she might — as a special "favor" to a friend — suggest that the friend take the medicine for "a similar condition." This potentially-dangerous, patient-to-patient "diagnosis" is **unlikely** to occur if the Rx is written.

Reason No. 6: A prescription given orally to a patient eliminates an exact written Rx record — stored at a pharmacy — as to what medicine was actually prescribed. This record can come in very handy — with respect to protecting the physician against the ever-increasing number of malpractice suits.

From the above 6 reasons, it appears rather clear that **written** prescriptions are in the best interest of both the public and the physician. Aside from preventing errors, a written prescription will generally avoid any delay in getting the proper medication . . . to the proper patient . . . at the proper time.

Consequently, when medication is to be prescribed — pursuant to a phone call or even during an office visit or house call — a **written** prescription is advisable.

If a written Rx is inconvenient or not possible, it would be best for the physician to say to the patient: "What is the phone number of your pharmacist? I will phone a prescription to him." Or perhaps the physician can say: "Please ask your pharmacist to phone me."

Drug orders, therefore, are best communicated directly from the physician to the pharmacist — whether the communication be via a written prescription or via the telephone.

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REPORT ON ACTIONS OF THE HOUSE OF DELEGATES AMERICAN MEDICAL ASSOCIATION 112th ANNUAL MEETING

June 16-20, 1963
Atlantic City

Enlargement of the Board of Trustees, the sections and scientific program of the AMA, interns and residents, a new Institute for Biomedical Research, a physician's pension plan and the relation between tobacco and disease were among the major subjects acted upon by the House of Delegates at the American Medical Association's 112th Annual Meeting held June 16-20 in Atlantic City.

Dr. Norman A. Welch of Boston, member of the House of Delegates since 1951 and Speaker of the House since 1959, was named President-Elect of the Association by acclamation. Dr. Welch will become President at the June, 1964, annual meeting in San Francisco, succeeding Dr. Edward R. Annis of Miami, Florida, who assumed office at the Tuesday night inaugural ceremony in Atlantic City.

The AMA 1963 Distinguished Service Award was voted to Dr. Lester R. Dragstedt of Gainesville, Florida, research professor of surgery at the University of Florida School of Medicine, for his achievements in the fields of education, research and practicing surgery.

Final registration figures at the meeting reached a grand total of 36,811, including 12,924 physicians.

Board of Trustees

The House adopted amendments to the Constitution and Bylaws designed to implement the recommendations presented in June, 1962, by the Ad Hoc Committee on the Board of Trustees. The changes will increase the size of the Board from 11 members to 15 members, by adding three elected trustees and including the immediate past president for a one-year term. The amendments also set the term of office for elected Board members at three years and limit the number of terms to three, for a maximum total of nine years service. In approving the amendments, the House expressed the opinion that enlargement of the Board of Trustees "would improve communications between the Board and the Association" and that the proposed changes "would be consistent with the increase in membership of the Association and with the increase of the size of the House of Delegates."

AMA Sections and Scientific Program

In considering the report of the Ad Hoc Committee to study the Board of Trustees Report on the Sections and Scientific Program of the AMA, originally presented at the 1962 Clinical Meeting in Los Angeles, the House disagreed with some recommendations in both of those reports.

Major change was the House decision that all section officers — chairman, vice chairman, delegate, alternate delegate, secretary, assistant secretary and representative to the scientific exhibits — should be elected by members of the section and that no officers be appointed by the AMA Board of Trustees.

In another change, relating to nominations for specialty boards, the House approved the following recommendation: "The Committee of the Council on Scientific Assembly of the appropriate section shall nominate the AMA representatives to serve on the medical specialty certifying board. These nominations shall be submitted to the Board of Trustees."

In connection with section registration, the House decided that "a member of a section who desires to change his registration from one section to another because of a change in his specialty, shall be required to inform AMA Headquarters by written notice of this intention at least sixty days in advance of the Annual Meeting."

The House agreed with the Ad Hoc Committee's recommendation that the Section on Gastroenterology and Proctology be renamed the "Section on Gastroenterology" and that a separate "Section on Proctology" be established.

The House also commended the Board of Trustees for its recommendation that a national forum be sponsored by the AMA in which representatives of national medical specialty societies and the Academy of General Practice will participate. The Board of Trustees was directed to implement this suggestion as early as possible.

Interns and Residents

The House disapproved the report of the Council on Medical Service and the Council

on Medical Education and Hospitals on Compensation of House Officers. In so doing, it adopted the following statement:

"We therefore recommend that in view of the overwhelming opposition to the basic proposal contained in the report of the Council on Medical Service and the Council on Medical Education and Hospitals, the AMA record itself as opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage."

The House, while declaring that the joint council report "represents a well-intentioned effort to find a solution to a most difficult, if not impossible, problem," recommended that any future proposals on the compensation of house officers be thoroughly studied by the Law Department and Judicial Council before submission to the House of Delegates.

In another action, related to the controversial "25% rule," the House approved a revision of the Essentials of an Approved Internship which deletes the requirement for any stated proportion of foreign medical graduates and graduates of American and Canadian medical schools as an essential feature of any internship program.

New Research Institute

In acting upon two reports from the AMA Education and Research Foundation, the House approved the Foundation's announcement that it will establish and operate a new Institute for Biomedical Research.

The Institute will concern itself with intensive and fundamental study of life processes particularly as related to intracellular mechanisms. It will be composed of groups of dedicated, imaginative workers who are capable of significant scientific achievements through the interaction of their intellects and experiences, with unmatched facilities and maximum freedom from external pressures.

The Institute will be dedicated to pure, basic, non-disease oriented research, and it will not render medical service to patients and will not conduct a graduate training program leading to a degree. It is contemplated that the first research group should be functioning by early 1965.

Physicians' Pension Plan

The House approved establishment of an AMA physicians' pension plan under the provisions of the Self-Employed Individuals' Retirement Act of 1962, and noted that the Board of Trustees will make every effort to begin operation of the plan before the end of 1963 so that physicians will be able to participate this year.

The plan will be open to all AMA members and their employees who can qualify under the Act, Public Law 87-792 (Keogh Law).

The law allows a self-employed individual to set aside up to $2,500 or 10% of his annual income, whichever is less, in a retirement fund, with the first $1,250 being deductible. The individual must provide proportionate benefits for any employee who works for him more than 20 hours a week and more than five months each year.

Tobacco and Disease

The House agreed with a Board of Trustees report which concluded that the AMA should defer any definitive statement regarding the relationship of tobacco and disease. The report pointed out that the AMA is continuing its study of this important subject and is merely deferring any public pronouncement pending the availability of more information, including whatever may come from the study of a committee appointed by the United States Public Health Service.

In taking this action, the House declared that extensive research is still necessary for the complete answers on the cause and effect of many toxins, including tobacco. However, the House said that the AMA "has a duty to point out the effects on the young of the use of toxic materials, including tobacco, and these facts should be disseminated, particularly in our schools."

Miscellaneous Actions

In considering a wide variety of resolutions and reports, the House also:

Disapproved a Judicial Council opinion on the dispensing of glasses by ophthalmologists and reaffirmed the Council's interpretation of Section 7 of the Principles of Medical Ethics, as reported in the November 15, 1958, issue of the Journal of the American Medical Association.

Approved a Judicial Council opinion on physician ownership of drugstores, drug repackaging houses and pharmaceutical companies.

Approved of AMA participation in the recent formation of a Joint Commission on Medicine and Pharmacy.

Agreed with the Council on Legislative Activities that the House should take no official position on the "Liberty Amendment" but should call it to the attention of individual physician citizens.

Disapproved of federal funds for staffing new community mental health centers.

Took a position opposing the student loan provisions of the Health Professions Educational Assistance Act of 1963.

Urged all state and county medical societies to adopt and activate all phases of "Operation Hometown."

Recommended that local medical societies in the vicinity of medical schools assume the responsibility of establishing and maintaining clear lines of communication with medical students.

Approved the organization of the new National Council for the Accreditation of Nursing Homes, jointly sponsored by the AMA and the American Nursing Home Association.

Adopted the recommendations of the Committee to Study the Joint Commission on the Accreditation of Hospitals and suggested that the committee's report be distributed to constituent and component societies and hospital chiefs of staff.

Approved an alteration in the Association Bylaws which states: "The Council on Medical Education and Hospitals shall consist of 10 Active or Service members at least one of whom shall be a private practitioner of medicine who is not a faculty member of a medical school nor a member of a staff of a hospital associated with a medical school or university."

Commended the American Farm Bureau for its vigorous leadership in opposing unwarranted government interference and regulation.

Urged the widest dissemination to AMA members of a joint report by the AMA Council on Mental Health and the National Academy of Sciences-National Research Council on The Use of Narcotic Drugs in Medical Practice and the Medical Management of Narcotic Addicts.

Recommended that all AMA members and affiliates give strong support to the national tuberculin testing campaign proposed by the American School Health Association.

Directed the Speaker of the House to appoint an ad hoc committee to study the size, make-up and functions of the House of Delegates, its councils, sections and committees and to report its findings in June, 1964.

Opening Session

Dr. George M. Fister of Ogden, Utah, retiring AMA president, told the opening session that "our fight against federal dictation is not merely one of concern only to physicians and their freedom to practice the best medicine possible, but it also concerns, equally or more so, the individual citizen, all professions and the private enterprise system in this country." Awards announced were the AMA Scientific Achievement Award to John F. Enders, Ph.D., of Boston, and the Joseph Goldberger Award in Clinical Nutrition to Dr. John B. Youmans of New York City.

Inaugural Ceremony

Dr. Annis, in his inaugural address Tuesday night, stressed the importance of maintaining an attitude of individualism among the physicians of America, and he urged members of the profession to have the courage and individuality to fight for all political, economic and professional freedoms. The Distinguished Service Award was presented to Dr. Dragstedt, and the Scientific Achievement Award was presented to Dr. Enders.

Wednesday Session

Speaking at the Wednesday session, Dr. Annis declared that "now, more than ever before, there is an obligation for all of us to waive or at least to minimize any differences between or within regions, specialties or organizations and to stand together on fundamental principles of medical care and medical practice, of enterprise and of freedom for which our great Association has striven in the last 116 years."

Election of Officers

In addition to Dr. Welch, the new president-

elect, the following officers were named at the closing session on Thursday:

Dr. D. F. Ward of Dubuque, Iowa, vice-president; Dr. Milford O. Rouse of Dallas, Texas, speaker of the House, and Dr. Walter C. Bornemeier of Chicago, vice-speaker.

Dr. Percy Hopkins of Chicago and Dr. Raymond M. McKeown of Coos Bay, Oregon, were re-elected to the Board of Trustees for three-year terms. Dr. Robert C. Long of Louisville, Kentucky, was named to fill the one year remaining in the term of Dr. Hugh H. Hussey, who resigned to become director of the AMA Division of Scientific Activities.

Elected to the three new posts on the Board, created by the House action on Wednesday, were Dr. Dwight Wilbur of San Francisco, three years; Dr. Lester Bibler of Indianapolis, two years, and Dr. L. O. Simenstad of Osceola, Wisconsin, two years.

Nominated and elected to the Judicial Council was Dr. Walter Judd of Minneapolis, physician, former member of Congress and 1961 winner of the AMA Distinguished Service Award.

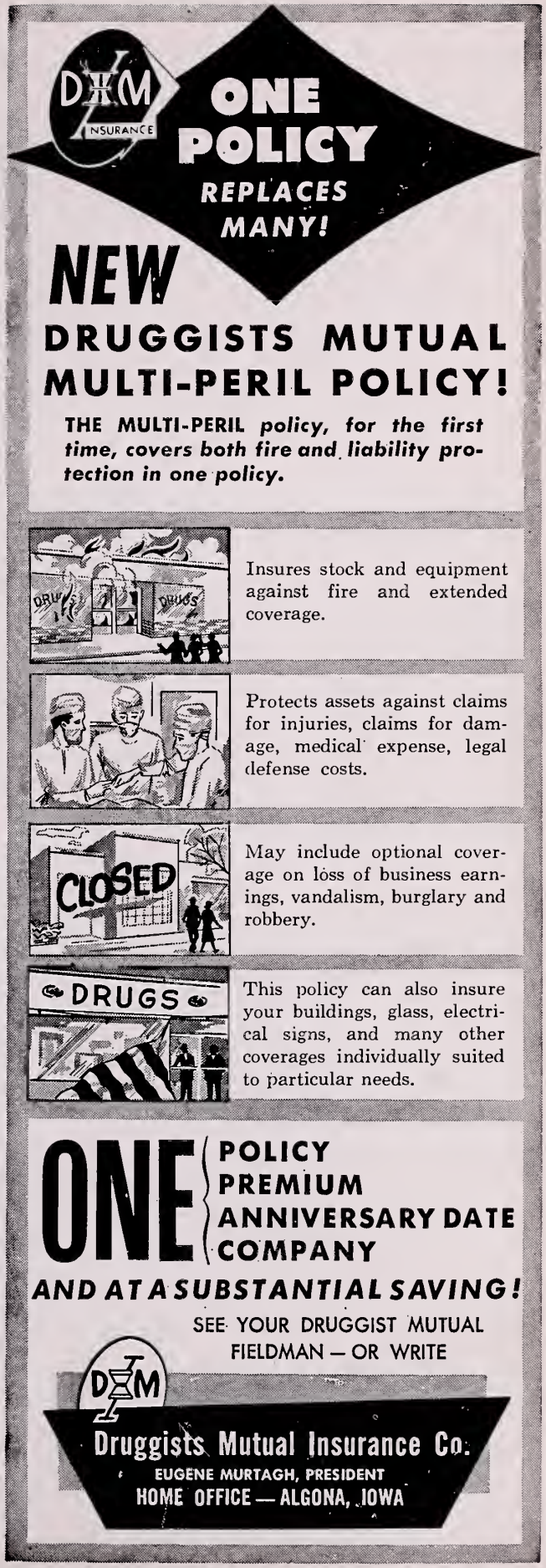
For the Council on Constitution and Bylaws, Dr. William D. Stovall of Madison, Wisconsin, was re-elected, and Dr. Thurman B. Givan of Brooklyn, New York, was named to replace Dr. Bornemeier.

Elected to the Council on Medical Education and Hospitals were Dr. E. Bryce Robinson, Jr., of Fairfield, Alabama; Dr. Francis L. Land of Fort Wayne, Indiana, and Dr. Melvin Breese of Portland, Oregon.

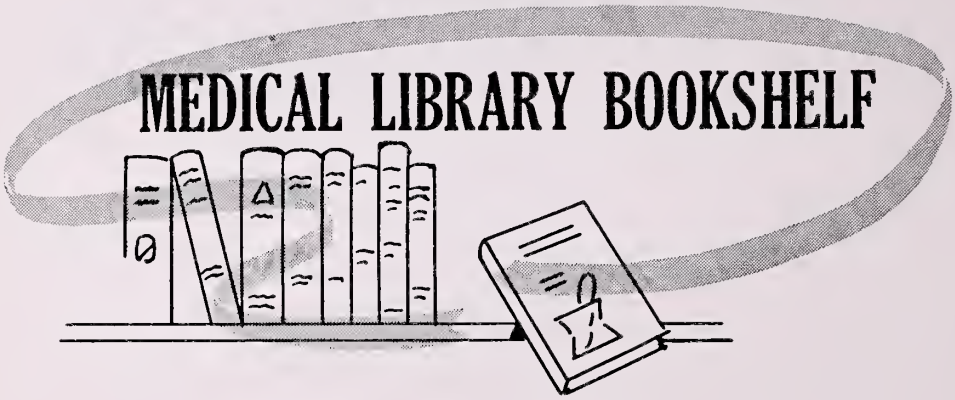
To fill vacancies in the Council on Medical Service, the House elected Dr. Burns A. Dobbins, Jr., of Fort Lauderdale, Florida; Dr. Irvin E. Hendryson of Denver, Colorado, and Dr. Jess W. Read of Tacoma, Washington.

By acclamation at the opening session, the House also expressed appreciation for the services of Mr. C. Joseph Stetler, the Association's general counsel and director of the Legal and Socio-Economic Division, who will be leaving July 1st to become executive vice-president and general counsel of the Pharmaceutical Manufacturers Association.

F. J. L. Blasingame, M.D.
Executive Vice-president
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NEW BOOKS IN MEDICAL LIBRARY

Collected Papers in Medicine and **Surgery from the Mayo Clinic and the Mayo Foundation,** Saunders, 1963. The material selected for these volumes is with the general practitioner, surgeon and diagnostician in mind. Advances made in medicine are covered in one volume and those in surgery in a second volume. Forty-seven of these articles appear in full, 106 in abridgment, and 84 in abstract form, with 420 by title only.

Among the full length articles is one on medical management of some of the esophageal disorders; arteriosclerosis obliterans; early carcinoma of the cervix; operative injury to the facial nerve; perplexing cystic masses near the kidney; profound hypothemia in neurosurgery, and open chest versus closed chest technique.

These authoritative books give vital new methods and techniques by men who have experience with many cases of common and rare disorders.

Arena, Jay M. **Poisoning,** Thomas, 1963. Dr. Arena is Professor of Pediatrics and Director of the Poison Control Unit of Duke University Medical Center. An important book for physicians to have close at hand. The chemistry, symptoms and treatments of various poisons with chapters on insecticides, rodenticides, fungicides, herbicides, fumigants and repellants included. A chapter on Drugs includes charts giving name, use, toxic effect and treatment.

Biochemical Clinics, Donnelly Corporation, 1963. Number 1. **The Heart**

Each issue of **Biochemical Clinics** will be devoted to an organ or system of the body, stressing the biochemical basis of clinical medicine. The first one on the heart includes under broad topics cardiovascular regulating mechanism; structural disorders, and functional disorders. More specific topics are: Ionic action in blood vessels; Management of heart block; Biochemistry of atherosclerosis; Mechanism and management of cardiac arrest and Cardiac resuscitation.

The chapters are all written by well known English and American specialists. Bibliographies are given at the end of each chapter.

The American Way of Life by Jessica Mitford, Simon and Schuster, 1963 is a gift book recently received in this library. It is an expose of the Funeral Industry making public many revealing facts that have for the first time been printed in book form. An article by Roul Tunley, "Can You Afford To Die" published in the Saturday Evening Post, June 17, 1961 brought a flood of letters to the Post, most of them protesting the prices and policies of the Funeral Directors.

Many aspects of the burial business are discussed including the psychological strategies employed by many undertakers for selling expensive funerals including metal caskets, vaults, special cosmetics, earth dispensers for the committal service and many other accessories.

The foundation of mortuary service is based on embalming which has made possible lucrative funeral service and elaborate funeral homes. There is widespread encouragement of the policy of the open casket and public viewing, which makes the restoring of the deceased to a life-like appearance through embalming, of prime importance. The family is often advised against permitting an autopsy because it results in a body that is difficult to show.

There has been an anti-P.O. (meaning Please omit flowers) campaign in which many newspapers have been persuaded by the Society of American Florists to refrain from using "please omit flowers" in their obituary notices.

A chapter is included on Funerals in England where the open casket and public viewing is considered in very bad taste; where caskets are made of wood and where vaults in the American sense of a metal or concrete container do not exist. The most expensive funeral is about $280 of our money as compared with an average of $1,450 for the funeral for every adult who died in the United States in 1961.

A final chapter "New Hope For The Dead" describes an increasing interest in Memorial Societies by those who believe it is time for reform; who want simplicity; more dignity; the opportunity of making their own decisions as to the manner in which the deceased is buried, without high pressure from funeral directors; and economical final arrangements.

Mrs. Esther Howard
Medical Librarian



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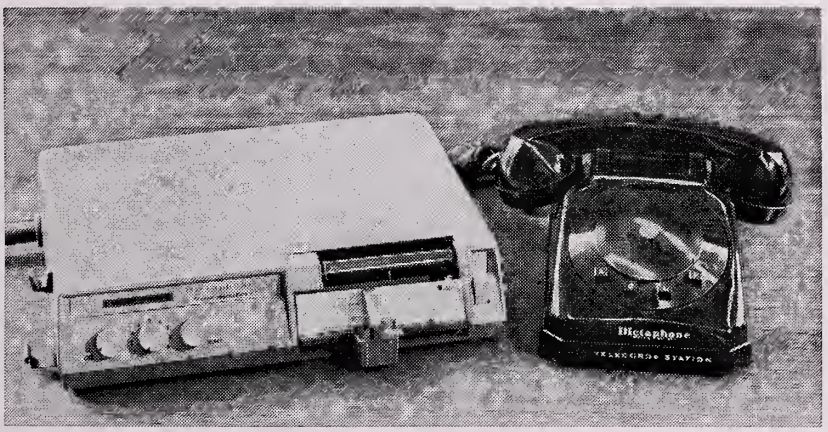
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NEWS • NOTES • • • BIRTHS • • • CHANGES • NEWS

Sioux Valley Medical Meeting will be held in Sioux Falls next winter. Dates are February 19, 20, 21 with 7th District hosting.

* * *

Don H. Manning, M.D., formerly located at 1000 S. Euclid Avenue in Sioux Falls, has moved his offices to the Koenig Building, 1320 South Minnesota Avenue, Sioux Falls.

* * *

E. S. Watson, M.D., of Brookings, has announced that a Sioux Falls psychiatrist, **Henry E. Davidson, M.D.,** will serve on a part-time basis with the Brookings Area Guidance Center.

Dr. Davidson serves as part-time director of adult out-patient services at the Minnehaha Guidance Center in Sioux Falls as well as maintaining a private practice.

* * *

An error was made in listing the recipients of the Distinguished Service Awards in the August issue of the Journal. The awards were initiated in 1951, at which time the recipient was T. F. Riggs, M.D., of Pierre. We extend our sincere apology for this oversight.

IT'S A PAIR AT LOCKWOODS

Mr. and Mrs. Ronald Lockwood (Phyllis Sundstrom) of Viborg became the proud parents of twin boys September 6, 1963. Mother and sons doing fine.

* * *

DR. LEEDS TO RAPID CITY

John F. Leeds, M.D., Hot Springs, has moved to Rapid City and become affiliated with the Western Dakota Medical Clinic. His associate in Rapid City is **N. R. Whitney, M.D.**

* * *

CALL FOR PAPERS FOR A.M.A. MEETING

Those who desire to present scientific papers before the Sections of the Scientific Assembly should communicate with the Secretary of the appropriate Section well in advance of the **deadline date, December 15, 1963.** The Secretaries and their addresses are listed in THE JOURNAL AMA in the last issue of every month.

* * *

Arthur A. Lampert, M.D., Rapid City, has been named honorary state chairman of the Sister Elizabeth Kenny Foundation's 1963 fund appeal.

The Journal wishes to apologize to Dr. Valkenaar of Chancellor for listing him as deceased in the 50 Year Club listing in the August issue of the Journal.

* * *

F. E. Manning, M.D., was recently honored at the 1963 Gold Discovery Days Pageant. Dr. and Mrs. Manning received an engraved silver plate in recognition of his fifty years of practice in Custer, South Dakota.

* * *

Shirley A. Claassen, M.D., is now associated with **Dr. R. H. Hayes** in Winner as a Pediatrician. Her medical practice will be for children under 16 years of age.

* * *

FISH FRY HELD AT SPEARFISH

The Black Hills District Medical Society held its annual fish fry on August 8th.

Approximately thirty doctors and their families attended the picnic which was held in the park at Spearfish.

The excellent meal was followed by a scientific presentation and business meeting.

Dick Erickson, of the Executive Office, was a guest at the event.

MONEY will be the subject of the 5th Annual Congress of the Professions to be held in Lansing, Michigan on February 7 and 8, 1964. Discussing topics related to the MONEY theme will be outstanding leaders of funds and foundations, financiers, and heads of governmental financial policy-making units. Officers and members of the South Dakota State Medical Association are invited to attend. Information can be obtained from Mrs. Helen Menton, Michigan Association of the Professions, 120 W. Saginaw Street, East Lansing, Mich.

* * *

New statewide plan for doctors and office personnel in Blue Cross-Blue Shield has had wide acceptance. Complete enrollment figures are not available but a good percentage have enrolled.

J. D. ALWAY, M.D. RETIRES

J. D. Alway, M.D., for 38 years a practitioner in the specialty of Eye, Ear, Nose and Throat in Aberdeen, has announced his retirement as of August 15th.

Dr. Alway was born in Graceville, Minnesota, and moved to Aberdeen when he was six years of age. He started practice with his father in 1925 in Aberdeen and has been there since. Dr. Alway at one time was a member of the Council of the South Dakota State Medical Association, and for ten years was President of the Board of Basic Science Examiners.

His plans are to remain in Aberdeen, sharing part of his time with Sun City, Arizona.

FOURTH DISTRICT MEET

The Fourth District Medical Society met on August 7th, at St. Mary's Hospital in Pierre. A short business meeting was held after which Dick Erickson, Assistant Executive Secretary of the State Medical Association, discussed the AMA's new legislative program, "Operation Hometown."

The group also viewed a film on "The Kidney and Its Functions."

* * *

Robert K. Johnson, M.D., has joined the staff of the Rapid City Medical Center, where he will devote his practice to internal medicine. Dr. Johnson is a graduate of the University of Rochester in New York; interned at Minneapolis General Hospital; and took his residency at the University of Iowa.



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RECIPIENTS NAMED FOR W. B. SAUNDERS COMPANY WRITING FELLOWSHIP AWARD

The extensive and enthusiastic response to the announcement of the Saunders 75th Anniversary Writing Fellowship has resulted in the awarding of two grants instead of the previously announced single award.

So many outstanding applications were received by the Selection Board from medical scientists of distinguished accomplishment, that an Executive Committee consisting of Robert F. Loeb, Rene J. Dubos, Henry Allen Moe, and Robert S. Morison recommended to the Saunders Company that it mark its anniversary with two equal fellowships, each in the amount of $15,000.

Saunders accepted this recommendation and announces that the two recipients chosen by the eminent selection board are Dr. Herman M. Kalckar, of Harvard Medical School, and Dr. Paul B. Beeson, of Yale University School of Medicine.

Dr. Kalckar will be writing on Biological Patterns of Cells in Developmental Defects and Disease States.

Dr. Beeson will be writing on Associations of Specific Infections with Certain Disease States of Man.

BATTLE LINES DRAWN ON MENTAL ILLNESS

The South Dakota State Medical Association through its Committee on Mental Health, and The South Dakota Academy of General Practice, along with the psychiatrists in the state of South Dakota, have made plans for a series of psychiatric seminars in various cities of the state. The same program will be given on consecutive days in each of three areas of the state by teams of psychiatrists, outlining the diagnosis and treatment of milder cases of mental illness in the offices of the doctors, particularly general practitioners, throughout the state.

The tentative schedule of dates is as follows:

October 2 — Sioux Falls, Huron and Rapid City

October 3 — Mitchell, Aberdeen and Rapid City

February 5 — Sioux Falls, Huron and Rapid City

February 6 — Mitchell, Aberdeen and Rapid City

April 1 and 2 in Yankton

The Yankton meeting will be a two-day, "follow-up," clinical meeting held at the State Hospital.

The movement, spearheaded by the American Academy of General Practice, was brought to its present status of readiness when psychiatrists and general practitioners met at the Denver Hilton on July 27th and 28th to determine how the general practitioner could be better trained to spot mental illnesses in early stages and either treat or refer his patients to someone else who specializes in that treatment. Attending the meeting from South Dakota were **A. P. Redding, M.D.,** Marion, South Dakota, who is a member of the National A.A.G.P. Mental Health Committee, and **Richard Leander, M.D.,** who is Chairman of the South Dakota State Medical Association's Committee on Mental Health.

Plans for the program set in motion are to continue for over a four-year period so that training programs can be given in all areas of the nation.

NATIONAL FOUNDATION TREATMENT CENTERS

At the present time in the United States, the National Foundation - March of Dimes has sixty-two Treatment Centers in operation for the evaluation and treatment of birth defects or juvenile arthritis.

Included are the Special Treatment Center for Arthritis at the University of Minnesota; a Birth Defects Center at Childrens Memorial Hospital in Omaha, Nebraska, and an Arthritis Special Treatment Center at Creighton Memorial-St. Joseph's Hospital, also located at Omaha.

These Centers have all been established by National Foundation-March of Dimes Grants

since 1958 when the National Foundation increased its scope to include these two crippling afflictions. This followed the development of the Salk and Sabin polio vaccines, both developed entirely by March of Dimes funds.

The grant made by the National Foundation chapters makes available a staff such as the one at Childrens Memorial Hospital which includes a neurosurgeon, orthopedist, pediatrician and medical social worker, and provides also for other specialists such as a plastic surgeon that may be called in if needed. The staff, working as a team, is then able to make a complete evaluation and in turn provide complete treatment.

Procedures for referral in regard to a child with a birth defect or juvenile arthritis, complete staff listings, location and prerequisites are included in the recently published Treatment Center Directory which has been distributed to all twelve Medical Districts in South Dakota.

Further information regarding the Treatment Center program can be obtained by contacting The National Foundation-March of Dimes, 2nd Floor, First National Bank Building, Sioux Falls.

THE AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Courses, 1963-64

The following courses are made possible by the generous cooperation of the directors and institutions involved. Tuition fees: Members, $60.00; Non-members, $100.00. Registration forms and requests for information should be directed to: Edward C. Rosenow, Jr., M.D., Executive Director, The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

Course 3 — Oct. 21-25

COMMON PROBLEMS IN ENDOCRINOLOGY AND METABOLISM: BASIC CONCEPTS AND CLINICAL APPLICATION, Marquette University School of Medicine, Milwaukee, Wis.; William W. Engstrom, M.D., F.A.C.P., Director.

Course 4 — Oct. 28-Nov. 1

ALLERGY AND HYPERSENSITIVITY STATES, Northwestern University Medical School, Chicago, Ill.; Samuel M. Feinberg, M.D., F.A.C.P., Roy Patterson, M.D., F.A.C.P., and Alan R. Feinberg, M.D., F.A.C.P., Co-Directors.

Course 5 — Dec. 2-6

ADVANCES IN THE MEDICAL ASPECTS OF CANCER, Francis Delafield Hospital, New York, N. Y.; Alfred Gellhorn, M.D., F.A.C.P., Director.

Course 6 — Dec. 2-6

PSYCHIATRY FOR THE INTERNIST, Los Angeles County General Hospital, Los Angeles, Calif.; Phil R. Manning, M.D., F.A.C.P., and Allen J. Enelow, M.D., Co-Directors.

Course 7 — Dec. 9-13

ENVIRONMENTAL MEDICINE, Massachusetts General Hospital, Boston, Mass.; Harriet Hardy, M.D., F.A.C.P., Director.

Course 8 — Jan. 6-10

NUCLEAR MEDICINE AND RADIATION BIOLOGY, University of California Medical Center, Los Angeles, Calif.; Joseph Ross, M.D., F.A.C.P., Director.

Course 9 — Jan. 27-31

NEWER CONCEPTS IN INTERNAL MEDICINE, co-sponsored by Louisiana State University and Tulane University, New Orleans, La.; G. Gordon McHardy, M.D., F.A.C.P., Director.

Course 10 — Feb. 10-14

HYPERTENSION AND ITS COMPLICATIONS, Eugene Talmadge Memorial Hospital, Augusta, Ga.; Thomas Findley, M.D., F.A.C.P., Director.

Course 11 — Feb. 24-28

RECENT ADVANCES IN METABOLIC DISEASES, The Mount Sinai Hospital, New York, N. Y.; Alexander B. Gutman, M.D., F.A.C.P., Director.

Course 12 — Mar. 2-5

NEUROLOGY FOR THE INTERNIST, Mayo Clinic, Rochester, Minn.; C. H. Millikan, M.D., F.A.C.P., Director.

Course 13 — Mar. 9-13

THE PHYSIOLOGICAL BASIS OF ELECTROCARDIOGRAPHY, University of Utah College of Medicine, Salt Lake City, Utah; Hans H. Hecht, M.D., F.A.C.P., Director.

Course 14 — Apr. 2-4

CURRENT CONCEPTS IN THE PHYSIOLOGY OF RESPIRATION, CIRCULATION, AND ELECTROLYTES, co-sponsored by The American Physiological Society, to be held in Atlantic City, N. J., Daniel H. Simmons, M.D., (Associate), and Charles R. Kleeman, M.D., F.A.C.P., Co-Directors.

Course 15 — May 11-15

CLINICAL AUSCULTATION OF THE HEART, Georgetown University Hospital, Washington, D. C.; W. Proctor Harvey, M.D., F.A.C.P., Director.

Course 16 — May 25-29

THE MEDICAL CARE OF THE ADOLESCENT, The Children's Hospital, Boston, Mass.; J. Roswell Gallagher, M.D., Director; Thomas E. Cone, Jr., M.D., and Robert P. Masland, Jr., M.D., Co-Directors.

Course 17 — May 25-29

RECENT PROGRESS IN ENDOCRINOLOGY, University of Washington, Seattle, Wash.; J. Thomas Dowling, M.D., (Associate), and C. Alvin Paulsen, M.D., Co-Directors.

Course 18 — June 1-5

RECENT ADVANCES IN CLINICAL NUTRITION, Lemuel Shattuck Hospital, co-sponsored by Tufts University School of Medicine and Harvard Medical School, Boston, Mass.; Thomas C. Chalmers, M.D., F.A.C.P., Director; Charles S. Davidson, M.D., F.A.C.P., Co-Director.

Course 19 — June 15-19

PSYCHIATRY FOR THE INTERNIST, The Baltimore Psychoanalytic Institute and Psychiatric Institute of the University of Maryland School of Medicine, Baltimore, Md.; Ephraim T. Lisansky, M.D., F.A.C.P., Director.

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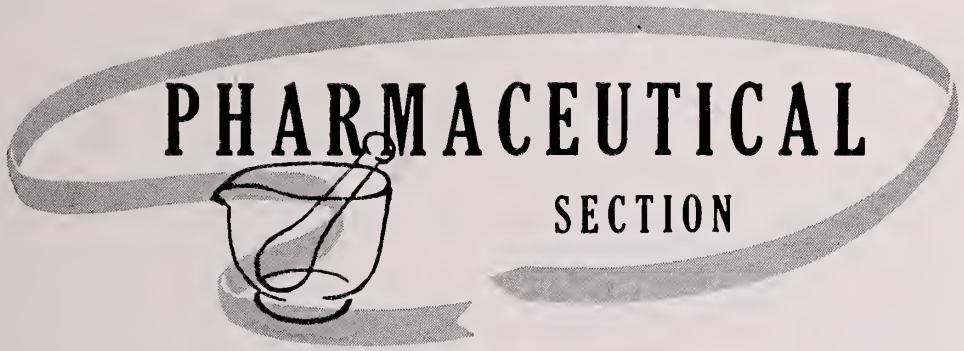
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GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota



PHARMACY, BY PHARMACISTS, IN PHARMACIES*

by
Lee E. Eiler**
Dayton, Ohio

Today I want to express my views on contemporary Pharmacy. At the outset I want to make it clear that my remarks are not directed at any individual but are made in the hope that they will contribute in a constructive way to the very considerable dialogue now going on within Pharmacy.

The reaction to my recent statements by some who opposed my point of view was not altogether unexpected, but the time is long past when pharmacists can live by the old concept of the past, in self assured complacency; change is upon us and we must meet it with new thoughts and concepts. The recent statement referred to earlier was the well-publicized statement made that "I believe there is no shortage of pharmacists, there are just too many pharmacies." I still hold that view and a manpower study recently completed by the U. S. Public Health Service further confirms it.

I would not belabor this point except that I also believe that this over-abundance of pharmacies is contributing directly to the basic problem that is facing Pharmacy today — the decline of Pharmacy as a profession.

An exercise in simple arithmetic tells us that if the number of prescriptions filled in this country last year were equally divided among the number of practicing pharmacists, each would fill approximately 20 per day. We know, of course, that many so-called pharmacies fill fewer than this. We also know that so few prescriptions cannot possibly support a professional and yet these pharmacies continue to show a nice profit. Why? Because they merchandise.

I've heard pharmacists elaborate with pride on their merchandising abilities while the subject of professionalism never comes up. They are so consumed with worrying about what their competitors, the grocer, the hardware store and the delicatessen, are doing that they completely ignore their real reason, or what should be their real reason for existence, the prescription and drug departments. The result has been a degradation of our public image as professionals.

Ironically, this deterioration of professionalism has occurred at the precise time in history when Pharmacy should have realized its most rapid and strongest growth as a profession. I refer to the advent of chemo-

*A speech presented at the 82nd Annual Convention of the Virginia Pharmaceutical Association, Arlington, Virginia, June 24, 1963.

**President of the American College of Apothecaries and member of the Council of the American Pharmaceutical Association.

therapeutic agents and synthetic drugs. Most of the advances in this field have occurred within the last 15 to 20 years and were concurrent with many of the problems existing in Pharmacy today. Pharmacy did not keep pace and we are still lagging behind.

While pharmacists, who professed to be experts on drugs, spent their time filling up acres of floor space with out-front merchandise, others with vision and professional perspective picked up the ball and ran with it. The pharmaceutical manufacturers and the physicians, largely out of necessity and partly out of lack of informed opposition from merchandising pharmacists, took over the research, marketing and regulation of the commerce of drugs to the extent that today we pharmacists have little, if anything, to do with this area of Pharmacy.

Consider for a moment who evaluates drugs for their safety and efficacy and therapeutic performance? Who determines how a new drug will be distributed to the general public? Who in your state is responsible for the assay of drugs produced **within** your state? I'm embarrassed to say that in mine it's the agriculture department!

And how about the over-the-counter drugs, do we pharmacists make an effort to screen these drugs as to their safety and worth? Or do we simply set them in an out-front aisle and so long as they are "turning over" or "moving" forget about them? Must we docilely accept everything the hucksters create a sale for, regardless of its benefits to the public? Are we really serving the public interest as pharmacists and experts on drugs?

The painful truth is that the majority of pharmacists have relegated **themselves** to pseudo-professionalism by defaulting their professional obligations for the role of merchandising.

Only now when mass production and changing distribution patterns are threatening these ventures, are pharmacists belatedly beginning to realize that their one real forte is the license that hangs in the long-neglected prescription department. Sadly enough we are learning that even this can be, and is, merchandised to the highest bidder. The only cost to the pharmacist who does so is the slight discounting of his personal pride and his profession. He fails to see that he is being used merely as a decoy by these mass merchandising giants to lend the virtues of prestige and dependability of Pharmacy to an otherwise merchandising operation. The pharmacist who sells himself to these operators seldom serves any real public need — the basis upon which professional service must be judged.

The 1199 Drug News, an official publication of the Drug and Hospital Union of New York did their own study of Pharmacy and came up with this opinion:

> "Every profession owes a service to the public which supports it and every profession properly seeks to secure the economic and prestige position for its members.
>
> "This dual responsibility is realizable where public needs can be fulfilled by less or optimum numbers rather than by too many professionals. On the other hand, overservice to the public concomitant with an oversupply, inevitably ends in a deterioration of the quality of service to the public."

Nowhere is this deterioration more apparent than in the limited service; limited, low-cost, fast turnover prescription stocks philosophy of the discount pharmacies which have recently burgeoned.

Pharmacy's Needs

While the problems in Pharmacy are vast and many pharmacists are even beginning to question the profession's chances for survival, no problem ever existed for which there was no solution. And this is true of Pharmacy today. There is a solution to our problems. But first we must analyze exactly what these problems are, then we must decide what our course of action will be to solve them and finally we must have the courage and stickability to work our plans.

Let me emphasize now that I have never advocated the closing of 35,000 pharmacies or any policy that would result in such an upheaval as I have been quoted.

I do believe, however, that we need to strengthen our Boards of Pharmacy and the licensing laws for community pharmacies in all states. These laws should be standardized as much as possible throughout the 50 states and should clearly define what constitutes a pharmacy. They should restrict ownership

and supervision to pharmacists only, and, if need be, pharmacies should be franchised by the Boards of Pharmacy (as in many European countries) so that the establishment of a pharmacy could be based upon the need for this service within a community. In time this would eliminate the pharmacy that fills less than 20 prescriptions per day and assure the pharmacist an adequate income from his professional practice.

The next thing we need to do is to make sure that the number of students entering and graduating from our colleges of pharmacy do not exceed the number required to maintain both themselves and adequate pharmaceutical service to the public.

Pharmacy education must be widened in scope to better prepare the pharmacist for the role of drug consultant because as each specialty in medicine becomes more and more involved, the importance of selecting the exact drug will mean a thorough knowledge of its absorption, utilization and excretion by the human body. I see a need for the immediate expansion of courses such as pharmacology, biochemistry, physiology and anatomy, if, as we claim, we are to be qualified consultants on drugs.

And in many areas of the country there is a need and an opportunity for pharmacists to enter the field of orthopedic appliances, surgical appliances and similar health needs.

Recent discoveries in all areas of drug use promise an exciting and interesting future for pharmacists who aspire to be real drug consultants.

For example, the extent of incompatibilities among many of the synthetic drugs are only now beginning to be realized.

Physical Pharmacy will undoubtedly be a fascinating field for only recently it has been dramatically demonstrated that the proper formulation of a drug may have everything to do with its performance in the human body.

Pharmacists of the future must be academically equipped to discuss these and other subjects and they must be able to explain the relative merits of all drugs available for the treatment of a specific disease.

None of these things will be possible or will ever be accomplished without vision, determination and leadership on the part of pharmacists. No one is going to hand us professional prestige on a platter, nor will degrees added to the pharmacist's signature accomplish this purpose. These things can only be attained by the individual pharmacist himself by the manner in which he practices pharmacy from day to day and by his own evaluation of his professional role and the service he gives.

Pharmacists must return to the practice of Pharmacy in pharmacies, if they are going to properly serve the needs of the public. It bears repeating that whether Pharmacy survives or not will be decided ultimately by the public and when a pharmacist ceases to supply or have an interest in the health needs of the community in which he practices, he no longer has reason to exist, he ceases to be a pharmacist except in name only, and the public is the first to become aware of this.

I believe we are seeing a trend away from general pharmacies, I mean those who sell everything, by both the public and pharmacists and with the ever increasing number of younger pharmacists with extensive scientific training, the trend will accelerate.

Professionalism

Professionalism seems to be uppermost in the minds of the student interns and newly graduated pharmacists who come to my office in a steady stream. They are seeking a way to make the most of their training and the general drug store, especially those in which the prescription has become a sideline, no longer represents their goal. They want to practice Pharmacy and they want to practice it in a professional atmosphere.

For those independent owners who have already persuaded themselves that the practice of Pharmacy belongs in a professional pharmacy, the complete transition is even then sometimes difficult.

I recently visited several professional pharmacies. Most of them were beautifully appointed and most were located in professional buildings. But a number of them could not resist filling up the floor space with greeting cards, boxed candies and peanut vending machines.

They told me, somewhat apologetically, that these items would be eliminated when the prescription department "got going."

This is just the reverse of my thinking. I believe that you have to get rid of these items before you **can** get going. I did a few quick calculations after leaving these pharmacies and discovered that for the inventory investment in those items, these pharmacists were receiving a return of pennies a day. What they would lose in getting rid of them would be more than compensated by the improvement in the professional atmosphere of these pharmacies — and this is true of many items in dozens of other pharmacies.

The upgrading of any pharmacy begins simply with the owner's decision to do so. He must decide that he will spend at least as much time promoting his prescription department and his services as he had formerly spent in pricing merchandise and buying sundries.

Sometimes I think that sundry salesmen do a real disservice to pharmacists by calling on them. They are often very persuasive and talk the pharmacist into buying just about anything if he can make a few cents profit on it.

When I visited a large city a few years ago I was struck by the probable income a dinner-ware salesman had made. Because about every drug store in town, I hesitate to call them pharmacies, had huge displays of it. Someone had made a killing on throw rugs, too. Some stores even displayed these in their windows.

In my opinion the pharmacists' time would be far more profitably spent in talking with professional medical representatives. I consider them a real asset to us and, as I have often told them, they are the only people who work for us who are not on our payroll.

All of the purchasing for our company is done by one man, a **pharmacist.** This eliminates salesmen calling on our managers individually to test their sales resistance and waste their time. I'm sure that over the years this has saved us a lot of money in inventories as well as helping us maintain stocks that are strictly professionally oriented.

Promising Future

I am not a doom crier. I believe that our profession has a rich and promising future — if — pharmacists return to the practice of Pharmacy in pharmacies, hospitals, public health agencies, nursing homes and in every area of research, manufacturing and education or anywhere else that our services are needed or where drugs are dispensed. If pharmacists truly returned to the practice of their profession in all these areas, there would probably be a shortage of pharmacists.

But as long as we default our duties and allow others who are often untrained to perform these services for the public in our stead, we neither deserve nor will we retain our professional status or prestige.

People and professions can and do change. Dentistry is a shining example of what can be done to improve and elevate the standards of a health profession from within through efficient organization. This can and must be done in Pharmacy. If we don't we are going to see more and more interference from all branches of government and from other encroachers who understand the importance of Pharmacy to the total existence of our society.

We must put away petty personal differences and work together for professional unity. Unity is vital to the proper performance of our professional duties and the protection of the public.

Part of the thalidomide tragedy rests with us, appalling as the thought might be. All of that drug has never been recovered. Have we moved fast enough and with determination to see that the distribution of clinical trial drugs is properly controlled so that such a tragedy is not repeated? It might never have happened in the first place had Pharmacy and pharmacists been militant in their duty to the public. The result has been that the Federal Government has taken over the role that we neglected, again by default.

Time is our enemy. We must work to unify Pharmacy at all levels and pharmacists must return to the practice of Pharmacy. We must face the facts as they are and not as we would like them to be. We can no longer blame the illusive, indefinable "they." Our problems were created by pharmacists and they can be solved by pharmacists if we face the truth squarely and act upon it.



FACTS ON THE OPERATION OF PRESCRIPTION PHARMACIES*

The Eleventh Annual Survey of Operating Costs of Prescription Pharmacies is sponsored by the American College of Apothecaries as a service to its Fellows and to the entire Pharmaceutical Profession. The study provides reliable indications of the costs of rendering services by those pharmacies whose prescription volume accounts for over 70 per cent of the total volume and provides an insight into the unique characteristics of this type of pharmacy compared to the general type pharmacy.

It seems imperative that the pharmacist be constantly aware of the costs involved in making good pharmaceutical service available so that he may be in a position to control those factors which are controllable and adjust his fees so as to provide the public with the best possible pharmaceutical service at fair and equitable costs. One of the purposes of this study is to provide all pharmacists with a better insight into the true costs of making pharmaceutical service available and to stimulate a critical evaluation of their operation so as to improve their managerial ability.

The 1962 Pharmacies

This year's survey of prescription pharmacies is based on a total of 196 pharmacies in a wide geographic area of the United States and includes a sampling of pharmacies operated by Canadian Fellows of the College. The "average" pharmacy represented in this year's survey had sales of $173,789. As shown in Table IV, 73.6 per cent of these sales were represented by the prescription area. This is, of course, a much larger percentage than would be shown by the national average of all pharmacies and is responsible for the unique characteristics and differences in operating costs which these pharmacies possess.

Not included in this figure of 73.6 per cent is approximately an additional 15 per cent of sales which go to the medical and allied professional groups, as well as a sizeable percentage of items in the health field such as surgical supports, hearing aids and so-called prescription accessories. However, it is interesting to note that the pharmacists reporting do not all conduct pharmacies which exclusively offer prescription services. In many communities and in many pharmacies the Fellows of the College do have available health needs and toiletries but all indicators point to the fact that it is the prescription area over the years that has contributed to the growth and strength of these operations.

A number of the pharmacists reporting in this survey have and operate multiple units and the 196 pharmacies actually represent 133 separate organizations with the average sales per organization being $255,253 and the total number of prescriptions on the same

* Prepared by The American College of Apothecaries.

basis being 47,129. These figures, if they can be projected on the basis of A.C.A. total Fellowship, indicate most clearly that the Fellows of the American College of Apothecaries account for a relatively large percentage of total prescription volume in the country in relationship to the number of pharmacies represented in the College.

A Direct Comparison

In the analysis of this year's survey much of the emphasis will be placed on those pharmacies which have reported both in 1961 and 1962. Every effort is made to encourage this since it is felt that with these sets of figures more reliable conclusions can be drawn which more clearly indicate trends. Of the 184 pharmacy reports analyzed last year, 166 reports were received this year which provides an excellent indication of the continuity of the reports indicated in the survey and, hopefully, an indication of the value of the individual analyses which are rendered those submitting their figures.

The comparative operating information on these pharmacies appears in Tables I and II. Despite the so-called increased competitive trends, these pharmacies were able to show an increase in average volume of 3 per cent. Although this does not represent a large increase, nevertheless it does reveal the relative strength of these operations against the pressures which have been developing.

Table I
Comparison of Operating Costs of Identical Pharmacies 1962 vs. 1961

	1962	1961	% Change
No. of Pharmacies	166	166	—
Average Volume	$174,856	$169,813	+3.0
Prescription Charges	75.6%	75.2%	+0.5
Cost of Goods Sold	55.8%	55.1%	+1.3
Gross Margin	44.2%	44.9%	-1.5
Total Expense	41.3%	41.9%	-1.4
Net Profit	2.9%	3.0%	-3.3
Total Net plus Owners' Salary	9.5%	9.7%	-2.1
Average Inventory	$ 29,422	$ 29,313	—
Average Prescription Fee	$ 3.63	$ 3.62	—
New Prescriptions	15,738	15,448	+1.9
Renewed Prescriptions	18,089	17,302	+4.6
Total Prescriptions	33,827	32,750	+3.3
Inventory Turnover	3.33	3.19	+4.4

Table II

	1962 %	1961 %	% Change
Owner's Wages	6.6	6.8	-3.0
Pharmacist's Salary	13.2	13.0	+1.5
Non-Professional's Salary	8.9	9.2	-3.3
Total Salaries	22.1	22.2	- .4
Rent, Heat, Light	4.0	4.0	—
Advertising	1.4	1.5	-6.7
Delivery	1.1	1.1	—
Depreciation	1.2	1.2	—
Taxes	1.1	1.1	—
Insurance	0.7	0.7	—
Telephone	0.8	0.8	—
Repairs	0.2	0.2	—
Miscellaneous	2.1	2.3	-8.7
Total Expenses	41.3	41.9	-1.4

The 166 pharmacies are actually part of 112 different operations with a number of the pharmacists operating multiple units. The average volume of each of these operations in 1962 was $259,162 as contrasted to a 1961 volume of $251,526, or an increase of 2.9 per cent per operation. The tendency toward multiple operations is continuing and this appears to be the result of the shifting lay and physician population. The establishment of smaller pharmacies in newer areas and neighborhoods, particularly where an existing pharmacy has a well established reputation, seems to be a necessary development if these pharmacies are to show continued growth.

Prescription Information

As indicated in Table I, those pharmacies reporting in both years showed an increase of 3.3 per cent in the total number of prescriptions dispensed in the face of the reduced number of new products introduced on the market as well as the reported decline in the number of prescriptions written by practitioners. As has been characteristic during the past several years the number of renewed prescription orders increased at a more rapid rate, showing an increase of 4.6 per cent although new prescription orders did increase but only slightly (1.9 per cent). The renewed prescription orders continue to increase as a total of the prescriptions dispensed with the 1962 total being 53.4 per cent as compared to the 1961 figure of 52.8 per cent.

An interesting factor revealed in this comparison was that of the prescription fee. Actually the average fee between the years of 1962 and 1961 in these identical pharmacies increased but 1 cent, an increase which cannot be considered significant. Thus even though prescription numbers increased, the stability of the prescription fee resulted in but a very slight increase in the per cent of prescription charges to total volume which in 1962 was 75.6 per cent.

A number of conjectures can be made from the prescription information but one fact seems evident that the reduction in the number of new products has an influence on both renewal rate and the prescription fee, increasing the former and stabilizing the latter. In the light of other information concerning operating costs, it would seem essential that the pharmacist continuously reevaluate his prescription charges for the past factors, namely, new prescription orders and more expensive newer medication, are no longer as evident and thus not capable of absorbing increasing operating costs as they have been in the past. Thus an appraisal of fees in the light of current operating costs is essential if an adequate economic structure is to prevail.

Cost of Goods Sold

The Cost of Goods Sold in these identical pharmacies increased in 1962 by 1.3 per cent to a total of 55.8 per cent. Although an apparently slight increase, nevertheless an increase which had a measurable effect on the profitability picture. Even with this increase this figure is still substantially below that recorded by the average pharmacy. Considering the costs of providing the professional services which should and must be offered by the prescription pharmacy or any pharmacy offering good professional service, this lower Cost of Goods Sold is essential if the prescription pharmacy is to operate on a sound economic basis.

Certain changes by manufacturers who sell direct or who formerly sold direct could well be responsible for this slight increase in Cost of Goods Sold. Almost all of those reporting in the study indicated they regularly take advantage of all cash discounts. Proper purchasing control is essential to make certain that the Cost of Goods Sold is maintained at a proper ratio so as to allow adequate Gross Margins to provide the services that the public needs and has every right to expect.

Gross Margin

As a corollary, the increase in Cost of Goods Sold produced a corresponding decrease in Gross Margin of 1.5 per cent, falling to a level of 44.2 per cent of total volume. This again represents a wide variation from the Gross Margin figures reported for so-called "average pharmacies" but this must be attributed to the unique characteristic of the prescription pharmacy type operation. This margin is essential in light of the fact that operating expenses in these pharmacies are much greater and in 1962 represented 41.3 per cent of volume. Although these total expenses for 1962 were somewhat reduced, the reduction in Gross Margin was even greater and thus the adverse result on net return.

As was pointed out in the discussion of the prescription information, the need for more closely evaluating the factors that contribute to Gross Margin and making whatever adjustments necessary, seems obvious from this year's report. The Gross Margin must be maintained at an adequate level if the operation is to continue to exist and this can only be done with a full realization of costs and adjustment of fees where necessary or a reduction in costs where possible. Also of course, an increase in professional opportunity and productivity can have an effect on Gross Margin. Yet the average pharmacist's cost accounting records, the proper analysis of them and the action taken on the basis of such analysis, all leave something to be desired. The costs of providing professional services are much higher and thus a high Gross Margin is necessary. However, it is also important to point out that in those pharmacies devoting a majority of their efforts toward the providing of professional services, they are utilizing their professional help much more effectively and economically and that if true cost accounting were employed, it would be shown that those pharmacies dispensing relatively few prescription orders have higher costs of dispensing each prescription than does the pharmacy with a large professional complement which utilizes the pharmacist for his primary purpose.

Thus in analyzing the Gross Margin required in these operations, it becomes obvious that to apply so-called standard marginal concepts of typical drugstore merchandise to the professional area, is completely illogical. There is no sound professional or financial basis for such a procedure and to do so is inviting difficulty and possible economic disaster.

Total Expenses

Total Operating Expenses for 1962 in this corresponding group of pharmacies were 41.3

per cent or a decline of 1.4 per cent. This decrease was most necessary in the face of a reduced Gross Margin and was the result almost exclusively of decreases in areas where the proprietor could exercise some control. The decrease was achieved primarily through the owner reducing his wages by 3 per cent, reducing advertising expenditures by 6.7 per cent and tightening up in the miscellaneous area, resulting in an 8.7 per cent reduction.

Also in the area of employees' salaries was a slight saving effectuated but the manner in which this was accomplished is of interest. Pharmacists' salaries were increased by 1.5 per cent but a reduction in non-professional employee salaries of 3.3 per cent resulted in a very slight decrease in total salary expenditure.

It is interesting to point out how important the human element is in the operation of the prescription pharmacy, a fact which contributes to its relative strength. Employees' wages, both professional and non-professional, account for over 53.5 per cent of the total expenses. If the owner's salary is included in this figure, the total rises to nearly 70 per cent of all expenses. This very fact makes it absolutely essential that every effort should be made to see to it that the proper type of personnel is employed, that they are trained adequately and that they are continually appraised as to their performance and effectiveness. The prescription pharmacy is dependent on the people and personal service and true management demands the proper attention to this most valuable asset.

In analyzing the expense factors besides salaries, those such as rent, heat and light, delivery, depreciation, taxes, insurance and telephone over which the pharmacist has relatively little control, remained stable. The miscellaneous expenses, which usually contains items which to some extent may be curtailed, showed a reduction. In this same category were the expenditures for advertising. This is frequently the first area where reductions are made in a tightened profitability picture but serious reservations can be raised as to whether such reductions are wise and whether increasing expenditures, properly evaluated, might not be more indicated at such times.

Total Return

As a result of the decrease in Gross Margin which was not compensated for by an equal reduction in expenses, the net profit for these identical operations fell 3.3 per cent in 1962 to a low level of 2.9 per cent of total volume. This reduction in net coupled by the reduction in reported owner's withdrawals produced a total return, before taxes, of 9.5 per cent or a decrease of 2.1 per cent over the previous year. This reduction in total return has become an annual trend with the pharmacies reporting in 1961 showing a higher total return.

It is important to recognize that these figures are before taxes and certainly do not represent an adequate return for the efforts and investment. Again the need for greater effective knowledge and control of the operation is spotlighted and the desirability of a constant analysis and readjustment of the basis for establishing fees for professional services is obvious. The increase in professional employee salaries points out that in order to attract good pharmacists and be in a position to offer a high type of professional service, which the public has every right to expect, adequate professional compensation must be provided. The pharmacy owner cannot continue to subsidize increasing costs from his total return indefinitely. A total reappraisal seems to be in order.

Inventory

The average inventory of the pharmacies reporting in both years increased very slightly from $29,313 to $29,422 or an increase of $109. This increase is below the increase in total volume and is an encouraging sign. With certain companies encouraging direct purchases, dire consequences of increased inventories were predicted. The figures in the study do not seem to bear out these prognostications. A good degree of control seems to be exhibited by the pharmacists. This figure represents about 16.8 per cent of volume and slightly less than that reported for the average community pharmacy.

In further exploring the inventory picture, certain facts are of apparent interest. For the purpose of this survey, average inventory is determined by adding the opening and closing inventories and dividing by two. In analyzing the opening and closing inventories

it was extremely interesting to find that the average opening inventory was $29,342 while the average closing inventory was $29,343, a difference which again indicates the extent of the control.

As might be expected, inventory statistics are not uniform and averages can sometimes be deceiving. However, the figures this year reveal an ever-increasing number of pharmacists who are making a sincere effort toward controlling the inventory problem. Interest and cooperation in this direction have been evidenced by some manufacturers who have adopted a realistic return goods policy. However, there are some manufacturers who by their policies are asking pharmacists to take losses due to conditions over which they have no control.

As an indication that inventory can be controlled by individual effort a close analysis of each report revealed that in comparing opening and closing inventories:

18.8 per cent of the pharmacies showed little or no difference.

37.5 per cent of the pharmacies showed a decrease in closing inventory while in

43.7 per cent of the pharmacies, closing inventories increased.

The Total Survey

The following tables and analyses are based on the total of the prescription pharmacies reporting and no effort will be attempted to show any comparative trends by the over-all figures other than in the following Table III, which shows the composite growth of the survey and percentages as they have developed over the years. The figures taken on a single year's basis can serve as a guide against which an individual pharmacist can evaluate his operation and thus be in a better position to determine how his operation compares to that of his associates.

Table III

How Does It Compare?

	1962 (196) %	1961 (184) %	1960 (164) %	1959 (181) %	1958 (154) %	1957 (107) %	1956 (95) %	1955 (59) %	1954 (48) %	1953 (38) %	Change 1961-62 %
Net Sales	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	—
Cost of Goods Sold	55.8	56.4	55.9	56.9	57.9	56.9	54.2	53.9	52.8	53.2	-1.1
Gross Margin	44.2	43.6	44.1	43.1	42.1	43.1	45.8	46.1	47.1	46.8	+1.4
Operating Expenses	40.7	39.9	39.9	38.6	37.6	39.1	40.7	41.1	40.3	40.4	+1.0
Net before Taxes	3.5	3.7	4.2	4.5	4.5	4.0	5.1	5.0	6.8	6.4	+5.4
Net Plus Owners'	10.3	10.9	11.3	11.8	11.8	12.0	13.2	13.4	14.1	13.9	-4.6

Table IV

Operating Cost of Prescription Pharmacies

	1962	1961
Number of Pharmacies	196	184
Average Sales	$173,789	$168,717
	%	%
Prescription Sales	73.6	67.5
Cost of Goods Sold	55.8	56.4
Gross Margin	44.2	43.6
Total Expenses	40.7	39.9
Net Profit	3.5	3.7
Net Profit plus Owners' Salary	10.3	10.9
Average Inventory	$ 29,342	$ 28,753
Inventory %	16.9	17.0
Average Number of Prescriptions	33,205	32,323
Average Prescription Fee	$ 3.62	$ 3.49
New Prescriptions	15,922	15,192
Renewed Prescriptions	17,283	17,131

Delivery Service

In analyzing Tables IV and V, it appears to be desirable to study some of the factors in somewhat more depth. One important service rendered by these pharmacies is Delivery Service. This has become a vital and necessary service offered by the pharmacist and can well serve as a stimulus to offset lack of parking and shifting population trends. It is frequently difficult to really ascertain the true cost of offering this service unless it is all handled on an outside contractual basis.

Table V
Total Expense Details of Prescription Pharmacies

	1962 %	1961 %
Owners' Salary	6.8	7.2
Employees Wages	21.3	20.5
Rent, Heat and Light	3.9	3.9
Advertising	1.4	1.6
Delivery	1.2	1.0
Depreciation	1.1	0.9
Taxes and Licenses	1.2	1.0
Insurance	0.7	0.7
Telephone	0.8	0.7
Repairs	0.2	0.2
Miscellaneous	2.1	2.2
Total Expenses	40.7	39.9

Tables VI, VII and VIII provide some insight into the distribution and nature of the pharmacies utilized in the study. This information may be helpful in interpreting some of the data presented.

Table VI
Regional Distribution of Reporting Pharmacies

New England	5%
Middle Atlantic	16%
South	19%
Midwest	37%
Southwest	5%
Rocky Mountain	3%
Pacific Coast	10%
Canada	5%

Table VII
Reporting Pharmacies in Population Centers of

Under 25,000	19%
25,000 to 50,000	11%
50,000 to 100,000	19%
Over 100,000	51%

Table VIII
Reporting Pharmacies Are Situated in

Medical Building/Center	42%
Main Business Area	33%
Neighborhood Area	25%

Of those pharmacies surveyed, delivery service, exclusive of salaries amounted to 1.2 per cent of sales. The details on delivery service which those pharmacies that kept adequate records were able to supply are tabulated in Table IX.

Pharmacist Employees

As previously indicated, employees' salaries account for well over 50 per cent of the total operating expenses. Again this year efforts were made to compile data concerning pharmacists' salaries and hours of employment. This information is summarized in Table X. An increase in the hours worked per week was indicated by the survey reports and correspondingly an increase in average weekly salary was also reported.

Mean Values

Mean Values were determined for a selected number of items in the operating reports and are included as a comparative guide to the pharmacist in Table XI. A mean value is sometimes more significant than an average for it represents the midpoint where 50 per cent of the reporting pharmacies were above the mean figure and 50 per cent below it. There are some variations between the reported averages and the mean, particularly in the area of net profit and total return.

Table XI
Selected Mean Values For 1962 Reporting Pharmacies

Total Volume	$184,897
Cost of Goods Sold	56.6%
Gross Margin	43.4%
Rent, Heat and Light	3.5%
Employee Salaries	17.0%
Total Expenses	41.1%
Net Profit	4.2%
Net plus Proprietors' Withdrawal	12.7%

The Cost of Dispensing a Prescription

The increasing interest in the fee method of charging for professional services prompted a detailed analysis into the costs of dis-

Table IX
Delivery Service

	1962	1961	1960	1959	1958	1957
Average Deliveries/pharmacy	46	44	54	52	63	60
Average Cost per Delivery	46c	47c	47c	44c	46c	43c

Table X
Pharmacist Employees

	1962	1961	1960	1959	1958
Average Work Week	44.3 hrs.	43.0 hrs.	44.5 hrs.	43.7 hrs.	44.9 hrs.
Average Weekly Salary	$159.70	$151.20	$145.60	$143.46	$134.20

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

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pensing a prescription. Once this factor is known, then the pharmacist can establish the rate of return which he feels is consistent with his needs. By this method he alone is responsible for the establishment of his fee for professional services.

For each of the individuals submitting a report the cost of dispensing a prescription was ascertained, utilizing the formula which has been recommended, namely:

Owner's Withdrawal + (% Prescription Vol. x All Other Expenses)
Total Number of Prescriptions Dispensed

Naturally there was a variation in costs due to the fact that operating costs in different areas of the country vary considerably. As can be seen in Table XII, the median cost (50 per cent above and 50 per cent below) falls in the $1.60 to $1.69 level, or actually $1.63. In determining an arithmetic average, by adding all of the individual fees and dividing by the total, the average cost of dispensing a prescription was $1.65. In utilizing the formula based on the figures for the "average" operation reported in the survey, the cost was calculated at $1.64. It is important to recognize that these figures are costs to which an equitable profit per prescription should be added to arrive at the professional fee. As a matter of information it seems desirable for all pharmacists to arrive at a cost figure for dispensing prescriptions so that they may have a better basis for establishing their charges for professional services.

Table XII
Costs of Dispensing Prescriptions

Cost	%	Cumulative %
Below $1.00	6.9	6.9
$1.00-$1.09	3.5	10.4
$1.10-$1.19	1.8	12.2
$1.20-$1.29	8.8	21.0
$1.30-$1.39	5.3	26.3
$1.40-$1.49	14.0	40.3
$1.50-$1.59	5.3	45.6
$1.60-$1.69	8.8	54.4
$1.70-$1.79	10.5	64.9
$1.80-$1.89	10.5	75.4
$1.90-$1.99	10.5	85.9
$2.00-$2.09	—	85.9
$2.10-$2.19	—	85.9
$2.20-$2.29	8.8	94.7
$2.30-$2.39	3.5	98.2
$2.40 & Above	1.8	100.0



AMERICAN HEART ASSOCIATION STAND ON SMOKING

(The American Heart, Vol. XIII, No. 3, 1963)

For the first time, the American Heart Association's Board of Directors has called for an active educational campaign to discourage smoking, especially among teenagers and persons with a high risk of coronary disease.

The action came with adoption by the Board of a report on smoking and cardiovascular disease prepared by a special committee of physicians and scientists. In a resolution the Board stated it "believes there is sufficient evidence of the harmful effects of smoking to warrant the AHA and its affiliates and chapters joining with other health agencies in educational programs to discourage smoking."

"High risk" individuals are those with a family history of heart disease or stroke in middle age, high blood pressure, high levels of cholesterol in the blood or any combination of these.

The report adopted by the Board reviews the scientific evidence which has become available since 1960 when the subject of smoking and heart disease was last acted upon by the AHA's top governing body. The 1960 report stated that a number of medical studies had demonstrated a statistical association between heavy cigarette smoking and increased death and illness from coronary artery disease.

These studies had shown that death rates in middle-aged men from heart attacks were from 50 to 150 per cent higher among heavy cigarette smokers than among nonsmokers. "This statistical association does not prove that heavy cigarette smoking causes coronary disease," the report stated, "but the data strongly suggests that heavy cigarette smoking may contribute to or accelerate the development of coronary heart disease."

The new report notes that additional evidence since 1960 confirms the earlier findings, and that no information has become available to contradict or invalidate them.

It points out that while the primary evidence of the harmful effects of cigarette smoking is still the statistical link between smoking and death from coronary disease, other health problems are involved. These include emphysema (lung changes which make breathing difficult), diseases of the arteries in the arms and legs, and lung cancer. The board therefore recommended that the AHA join other health groups in programs to discourage smoking.

The report also outlines areas in which research should be expanded:

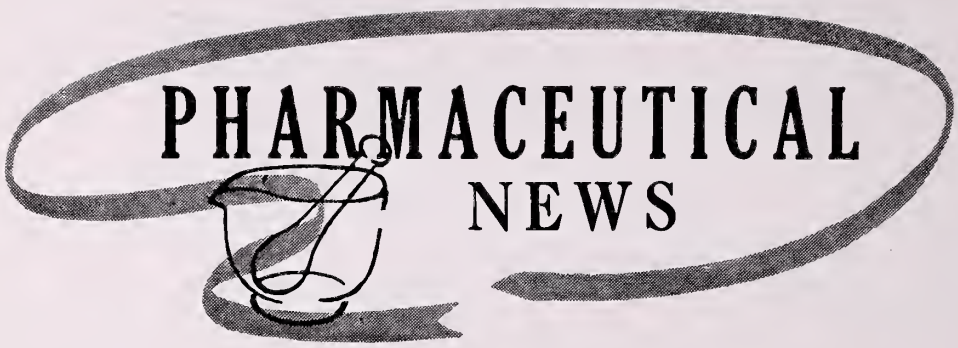
—correlation of smoking in population groups with diet, physical activity, heredity, emotions, blood clotting, blood fats and other possible factors;

—effects of giving up smoking among persons who have coronary disease;

—studies of the differences between the effects of cigarette smoking as opposed to pipe and cigar smoking, which seems not to be linked to heart disease.

The report of the Ad Hoc Committee on Smoking and Cardiovascular Diseases was adopted by the Central Committee for Medical and Community Program and approved by the Committee on Public Relations and Public Information.

Dr. A. Carlton Ernstene, chairman of the Cleveland Clinic's Division of Medicine and a past AHA president, headed the Committee.



SCHOLARSHIPS AWARDED TO THIRTY-THREE PHARMACY STUDENTS

Thirty-three students of the Division of Pharmacy, South Dakota State College, are the recipients of scholarship stipends for the 1963-64 academic year. Total awards for the year amount to $6,286.

Sponsors of the various scholarships and the recipients are:

Osco Drug — **John H. Burns,** Philip; **Theodore Westley,** Aberdeen; **Wesley Putnam,** Onida; **Robert Frick,** Sioux Falls; and **Douglas Carnahan,** Sioux Falls.

Pharmacy Special— **Michael Hausken,** Veblen; **Vernon Peterson,** Dell Rapids; **Steven Hoy,** Hot Springs; **Marvin Schmidt,** Blakeley, Minn.; **Mary DeLay,** Flandreau; **John Reinschmidt,** Clark; **Raymond Novak,** Huron; and **Richard Kingdon,** Huron.

Rowell Laboratories — **Catherine Carr,** Watertown.

E. R. Serles — **Mary Thoman,** Rapid City.

American Foundation for Pharmaceutical Education — **William Isaksen,** Springfield, Minn.; **Robert Schnell,** Sturgis; and **Loren Schweigert,** Gregory.

Austin Pharmaceutical Auxiliary — **Clayton Pike,** Austin, Minn.

John and Sara Griffin Foundation — **James Bowersox,** Sioux Falls.

George and Gertrude Frederickson Foundation — **Mary Waggoner,** Sioux Falls.

S. D. Pharmaceutical Association — **Marion Fiedler,** Java.

S. D. Board of Pharmacy— **Ronald Huether,** Wessington Springs.

Pepsodent — **Lee Gustafson,** Centerville; **Keith Roberts,** Pierre; **Rodney Parry,** Canistota; and **Leman Olson,** Viborg.

Stephen F. Briggs — **Joyce Hodgson,** Huron; and **Beverly Walker,** Huron.

Mathew Tiernan — **Karen West,** Mitchell.

F. O. Butler — **Gerald Mettler,** Aberdeen; **Dave Kuper,** Sioux Falls; and **Douglas Kapaun,** Sioux Falls.

FDA PAMPHLET EXPLAINS PROTECTION FOR NEW MEDICINES

A new Food and Drug Administration pamphlet called "Facts for Consumers—FDA Approval of New Drugs" has recently been made available.

The pamphlet tells about the tests the manufacturer must make and the information he must submit to FDA to get a clearance to market a new drug. It describes the procedures required to assure that experimental drugs can safely be tried on humans. And it tells how the law operates when new side effects are discovered after a drug gets on the market.

The pamphlet concludes that the controls over the safety and integrity of our drug supply are the strongest of any in the world today, and are an indispensable part of health protection under the Federal Food, Drug, and Cosmetic Act.

The pamphlet is available from the Superintendent of Documents, Washington 25, D. C. The price is 15 cents.

POLIO, OTHER SERIOUS DISEASES DOWN IN 1963

The health picture of the American people is looking bright this year with at least one serious disease—polio—approaching the vanishing point, and several others in decline, the Health Insurance Institute has announced.

The Institute, reporting on data on communicable diseases compiled by the U. S. Public Health Service for the first 26 weeks of 1963, said that in addition to polio, such diseases as hepatitis, encephalitis, diphtheria, measles, and typhoid fever also had lower incidence over the same period a year ago. Polio's decline was the most dramatic, however.

In the first 26 weeks of this year, 81 cases of polio were reported in the United States — 126 fewer cases than for the same period of 1962.

Polio's extraordinary decline is best illustrated, said the Institute, by comparing current figures with 1952 when a record 58,000 polio cases were reported during the full year. Incidence of the disease went into sharp decline after polio vaccination programs began in 1955.

Other Diseases

Hepatitis, a stubborn virus infection of the liver which has had very high incidence counts in recent years, also appears to be on the wane. A total of 23,639 cases were reported in the first 26 weeks of the year as against 31,654 for the same period in 1962.

The incidence of measles has decreased, as well. Some 335,000 cases were reported in the first half of 1963, a drop of 81,000 cases. Reported cases of diphtheria are fewer, too — 132 for the first 26 weeks compared to 219 a year ago, and typhoid fever cases declined from 246 to 182 for the first six months of 1963, according to the Institute.

Some communicable diseases were on the rise. Strep throat and scarlet fever, added together, increased by 18,000 cases for a total of nearly 215,000 cases reported in the first half of this year. Also increased, but slightly, were aseptic meningitis cases, with 627 cases reported for the 26-week period as compared to 606 in 1962, and tetanus, 112 cases in 1963's first-half against 106 a year ago.

PENNSYLVANIA BECOMES 6TH STATE TO AFFILIATE WITH APhA

Pennsylvania pharmacists voted July 23 at the annual meeting of the Pennsylvania Pharmaceutical Association to affiliate with APhA. Pennsylvania is the second state to vote to affiliate in 1963, and the sixth state to unite with the national professional society in the past year and a half.

Iowa was the first state to vote to affiliate in 1963 and followed earlier votes by Michigan, Delaware, Virginia and Wisconsin. With Pennsylvania, the six states that have voted to affiliate have 21,000 pharmacists resident in state. Eighteen other states have voted to study affiliation since Michigan began the movement with its affiliation vote in February, 1962.

DURHAM NAMED SPECIAL APhA CONSULTANT ON LEGISLATIVE MATTERS

The Honorable Carl T. Durham, former Congressman and co-sponsor of the Durham-Humphrey Amendment of 1951, has accepted an appointment as special consultant to APhA. Mr. Durham, a community practitioner of pharmacy from 1912 to 1938, will advise APhA on legislative matters.

Well-known for his interest in pharmacy and health matters, Mr. Durham was elected to Honorary Membership in APhA in 1943, and was presented with an APhA Citation for Distinguished Service by the Association in 1959, the year he retired from Congress.

He is a member of Kappa Psi Pharmaceutical Fraternity and is active in its affairs as advisor to the Beta Xi Chapter at the University of North Carolina.

Mr. Durham was born August 28, 1892, in Chapel Hill, N. C., his present home, and practiced pharmacy there until 1938 when he was elected to the U. S. House of Representatives. He served in the 76th through the 86th Congresses and was Chairman of the powerful Joint Committee on Atomic Energy for an unprecedented two terms.

Prior to his Congressional service, and while an employee pharmacist, he served on the Chapel Hill school board, county commission and board of aldermen.

He attended the University of North Carolina and received an honorary doctorate

from that school and from High Point College of High Point, N. C. He has served as a trustee of the University of North Carolina for a number of years.

LIFE-SPONSORED PHARMACY AD REACHES 25 MILLION READERS

"More than 25 million readers of **Life** saw the 'Member of the Team' institutional advertisement sponsored by the magazine in the past ten months," said APhA Executive Director, William S. Apple. Approximately 90 per cent of **Life's** circulation ran the ad once with another 20 per cent carrying the ad more than once.

"If pharmacy had to pay for this space, the cost would have been at least $46 thousand and probably more," Dr. Apple explained. The entire profession is indebted to **Life's** promotional department and Mr. Joseph Curran, of **Life's** staff, who has been working closely with APhA on this project.

Plans for additional advertisements have been formulated and layouts are already being prepared. Three of the new ads will mention the practicing pharmacist, while a fourth will be devoted entirely to explaining the role of the community pharmacist.

This joint **Life**-Pharmacy project is designed to bring greater public recognition to the community pharmacist. That the project has been successful is clearly indicated by the number of ad reprints ordered from **Life.** Mr. Curran reported that more than 25 thousand reprints of "Members of the Team" have been requested since the ad first appeared and was announced to state and local pharmaceutical association secretaries by the American Pharmaceutical Association.

ACA TO SPONSOR CONTINUING EDUCATION PROGRAMS

The projected nation-wide Continuing Education Program of the American College of Apothecaries will be formally presented in a "pilot" demonstration at the A.C.A. Annual Convention October 27-30th at the Greenbrier, White Sulphur Springs, West Virginia.

The A.C.A. has been formulating plans to sponsor refresher seminars for pharmacists across the nation, with the programs being arranged and executed under the direction of the 13 Regional Directors of the College.

The pilot presentation at the Greenbrier meeting on Wednesday, October 30th, will be a full-day schedule of lectures and discussions. It will be conducted by two Faculty Fellows of the College: Dean Arthur Zupko of the Brooklyn College of Pharmacy, Long Island University and Dr. Martin Barr, Professor of Pharmacy at Wayne State University College of Pharmacy. In four presentations the speakers will cover important topics in the area of community practice.

"We view such a continuing education program as an indispensable aid to the community pharmacist who would strive to remain an informed and competent practitioner of his profession. With available time usually at a premium, the pharmacist can achieve significant benefit from carefully planned Continuing Education projects held in his area," said A.C.A. President Eiler in announcing the project. "Both basic and advanced subjects can be presented to refresh and to broaden the community pharmacist's areas of knowledge."

Eiler also emphasized that the pilot Continuing Education program and all A.C.A. convention sessions are open to all pharmacists. He invited all pharmacists to attend. Full details about registration and accommodations are available from the American College of Apothecaries, Hamilton Court Hotel, 39th & Chestnut Streets, Philadelphia 4, Pennsylvania.

MRS. LOWER PASSES AWAY

Mrs. Guy Lower, Howard, South Dakota, an employee of Rafferty Drug since 1935, passed away suddenly of a heart attack on September 3rd. Sympathy is extended to Mr. John Lower, Sioux Falls, Professional Sales Representative for Schering Corporation, Mrs. Al Knutson, Knutson Drug, Clark, South Dakota and Mr. Robert Lower, Bacon Drug, Excelsior, Minnesota.



The Lady Governors of the Old Men's Home at Haarlem FRANS HALS, 1580/81-1666

In Geriatrics...

METAMUCIL® Provides Bland Smoothage

brand of psyllium hydrophilic mucilloid

The tendency of the elderly to subsist on low-residue foods often is a prime cause of bowel sluggishness. Adequate fecal content is necessary to maintain normal colonic function, since intracolonic distention is nature's method of stimulating reflex peristalsis.

Metamucil, therefore, fulfills a basic function in the treatment of geriatric constipation. It both softens hard, dehydrated fecal concretions and adds smooth, nonirritant, easily compressible hydrophilic bulk.

Metamucil applies a physiologic principle to correct constipation naturally.

Average Adult Dose: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid. To Metamucil powder, a refined, purified and concentrated psyllium hydrophilic mucilloid, an equal amount of dextrose is added as a dispersing agent. Each dose of the powder furnishes a negligible amount of sodium and 14 calories. To the mucilloid in Instant Mix Metamucil citric acid, sodium bicarbonate and mild flavoring are added. Each dose of Instant Mix Metamucil furnishes 0.25 Gm. of sodium and 3 calories. Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

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Helps speed recovery even in severe muscle injuries

Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. *(Clinical Medicine*, March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely. For severe athletic strains or everyday sprains, you can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with
an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories, Cranbury, New Jersey

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with Persantin,® brand of dipyridamole

See next 3 pages

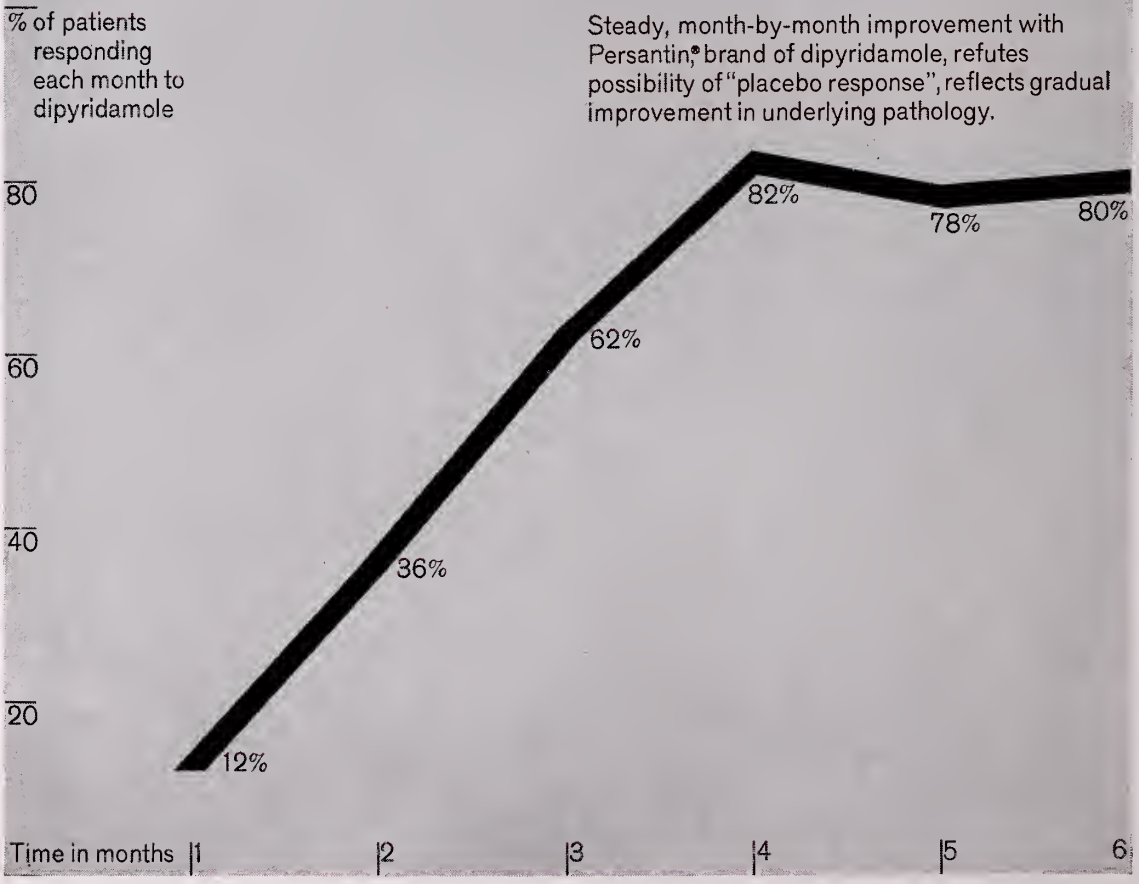
Study 1.
Griep,A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole: A Report of Fifty Cases. Angiology 14:484, 1963.

Persantin,® brand of dipyridamole, 25 mg. t.i.d. or q.i.d.,was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis; final evaluation after 6 months showed that 56% of patients were completely free of, or had markedly fewer, anginal attacks, with normal or improved ECG findings; an additional 24% experienced fewer, milder attacks and improved work capacity.

Persantin®
brand of dipyridamole

"...long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients... relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"

Steady, month-by-month improvement with Persantin,® brand of dipyridamole, refutes possibility of "placebo response", reflects gradual improvement in underlying pathology.



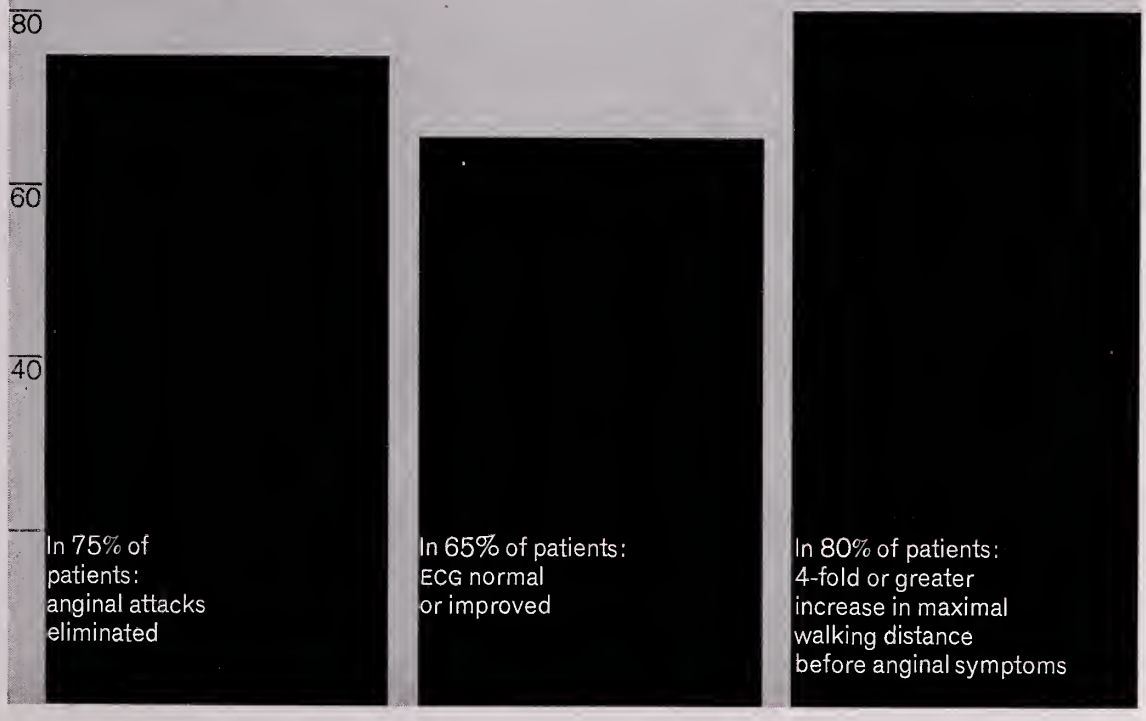
Study 2.
Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin,® brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

Results after 3 months of therapy revealed a satisfactory clinical response in 32 patients. The accompanying diagram illustrates the specific criteria of improvement in patients with excellent or good response.

Of 40 patients, 32 showed "...reduction or abolition of acute anginal attacks...complete or almost complete disappearance of ECG abnormalities... marked increase" in walking distance without anginal symptoms

Response after 3 months of continuous therapy with Persantin,® brand of dipyridamole



How Persantin,® brand of dipyridamole, provides long-term clinical benefits reported on previous pages

1. By increasing energy yield
of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).[1-5]

2. By improving collateral coronary circulation.
Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.[6-9]

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

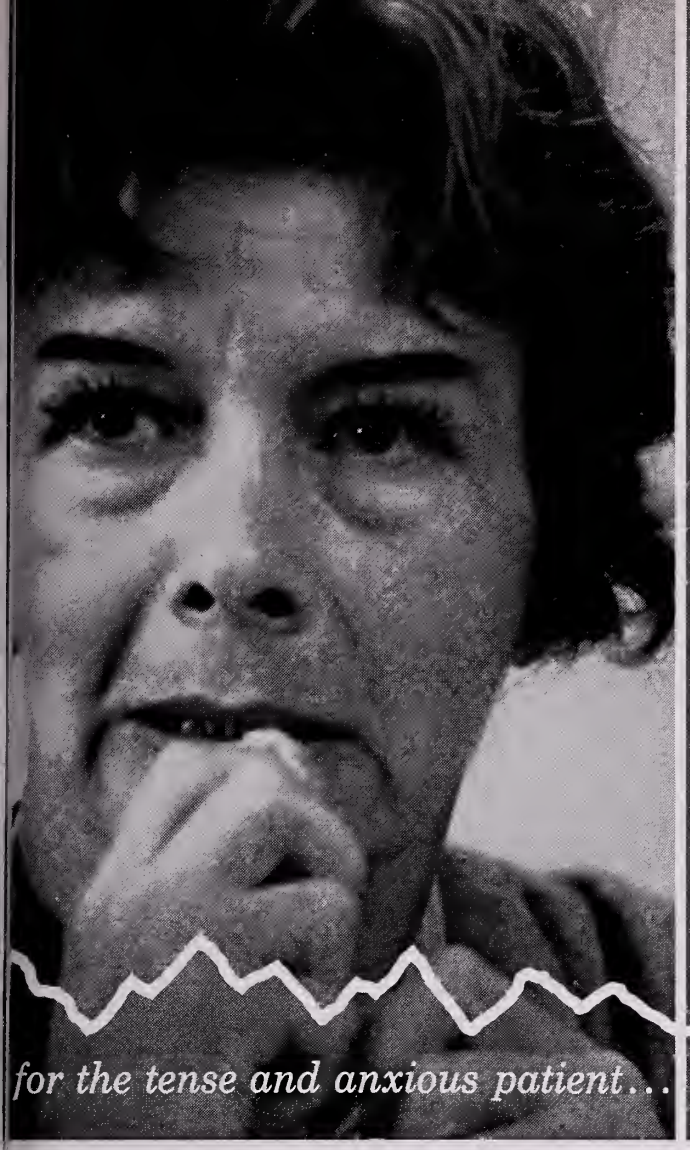
Availability:
Tablets of 25 mg., bottles of 100 and 1000.
Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

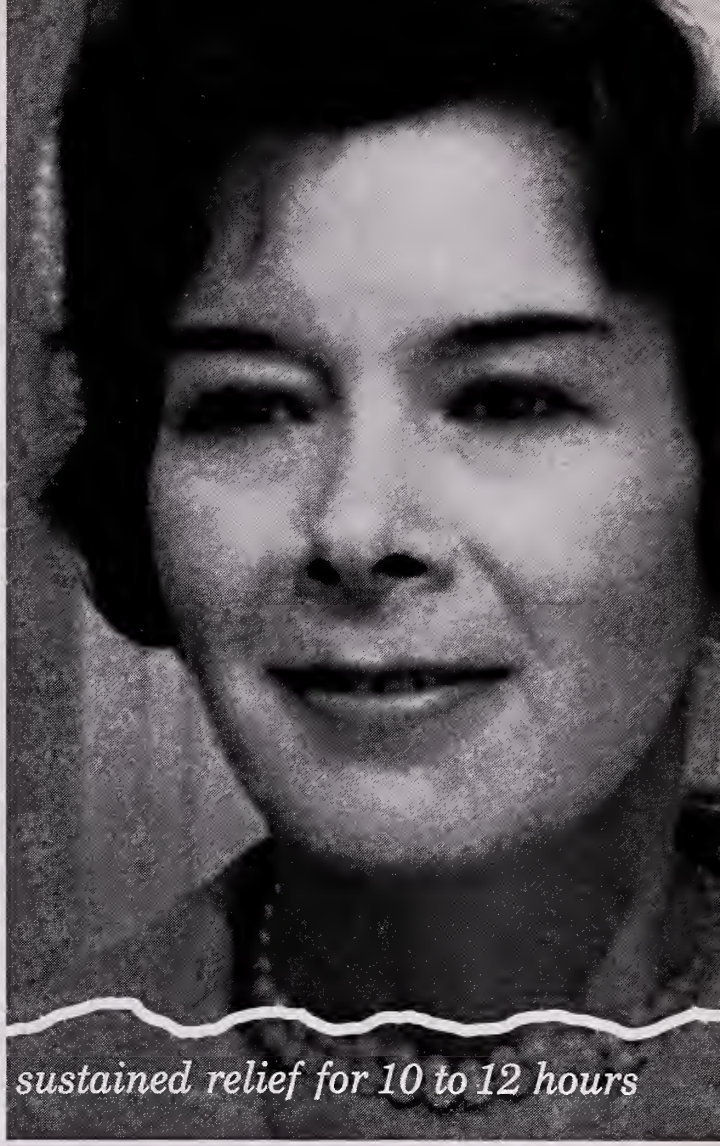
References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.27:849,1962.

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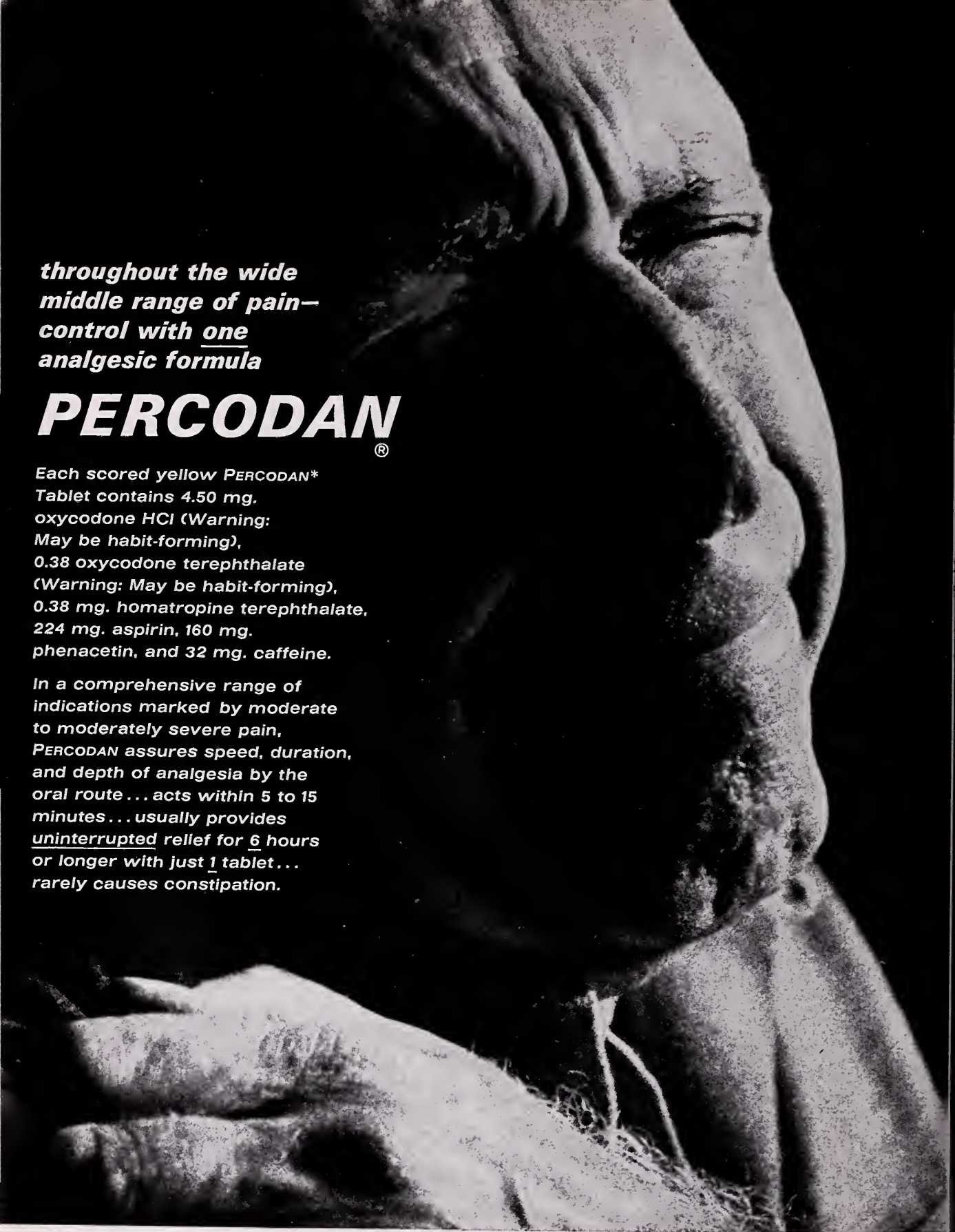
Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

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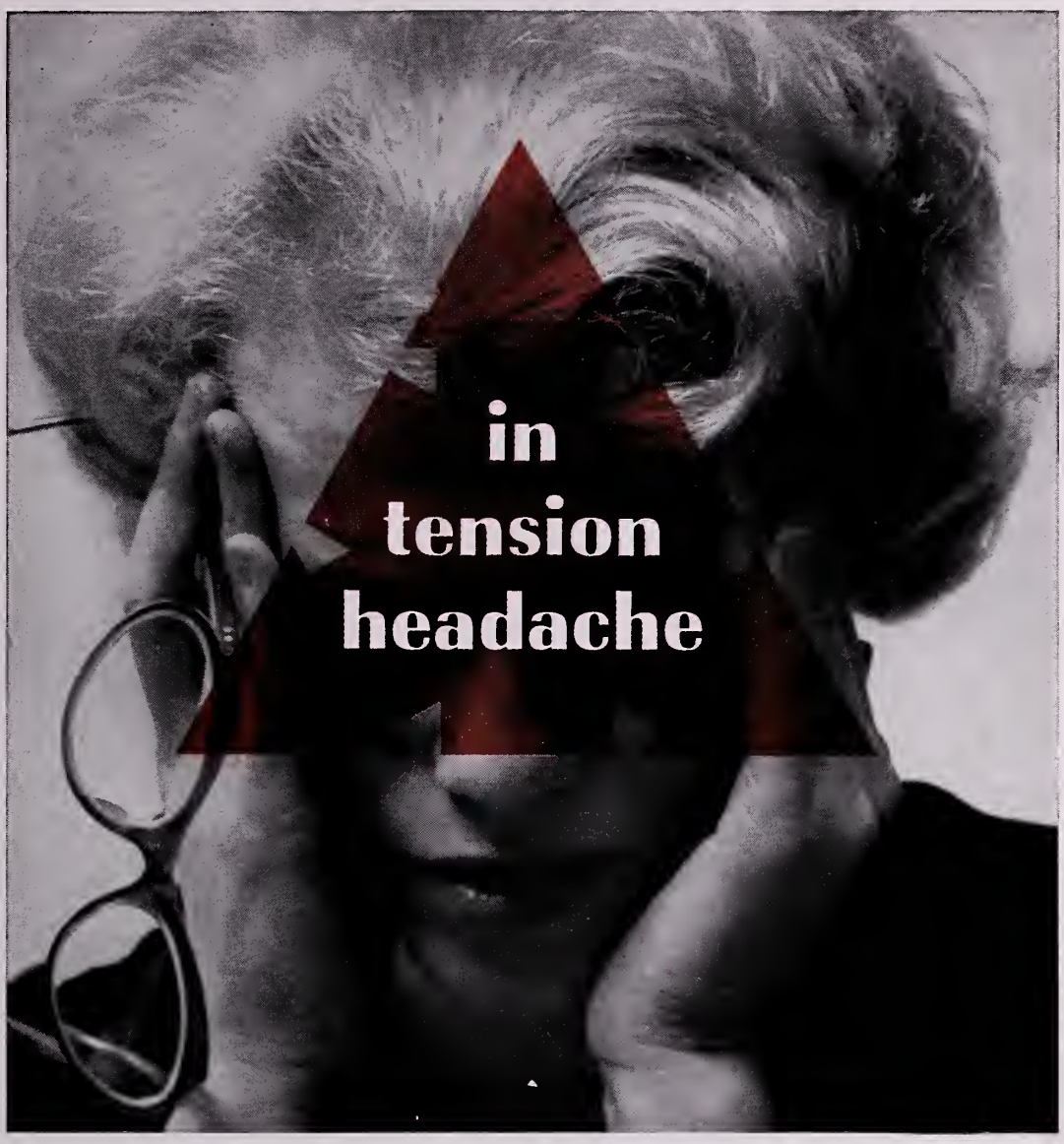
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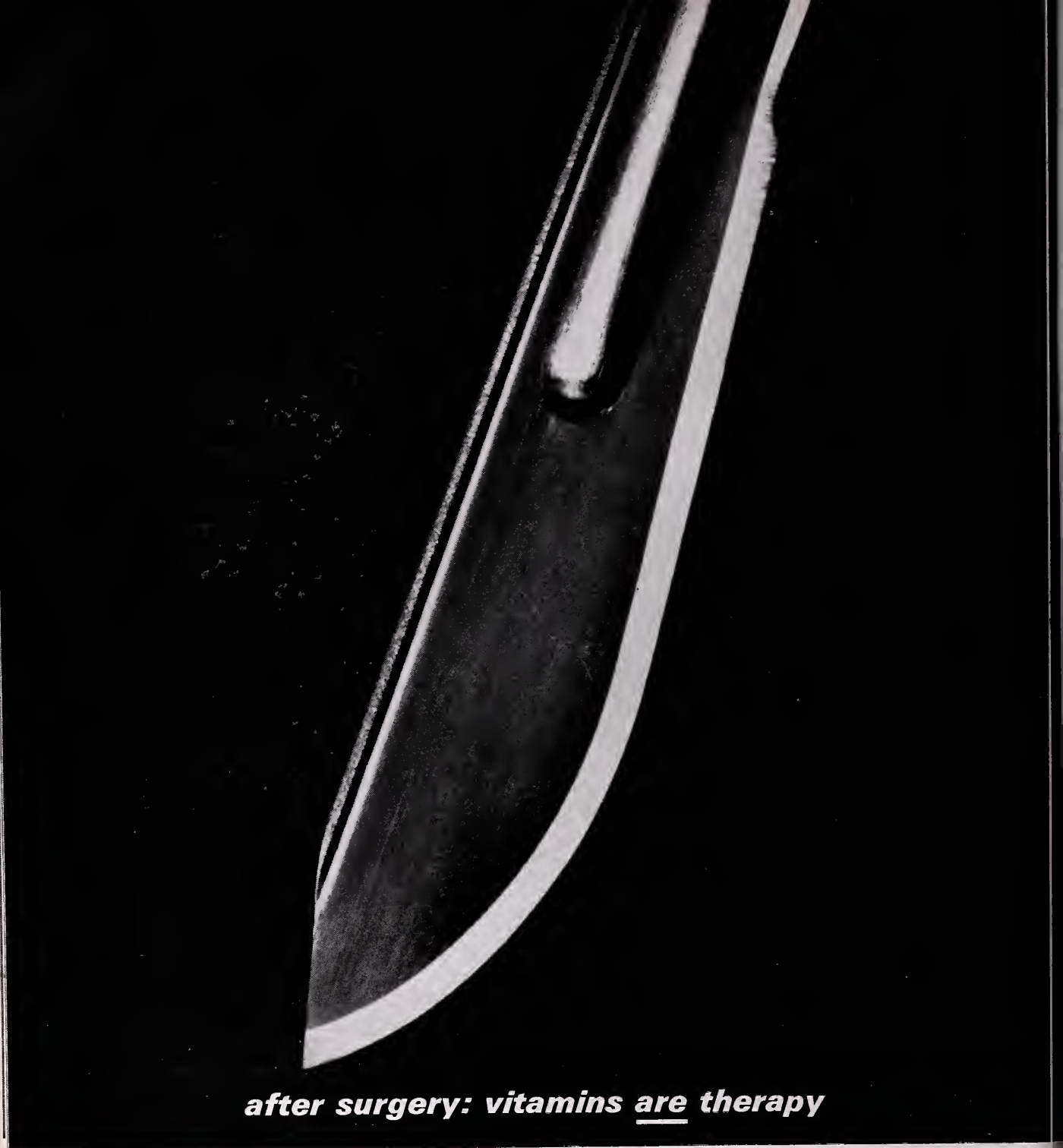
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Side Effects and Precautions: Prolonged administration can produce mild hirsutism, acne or voice change. In an occasional patient, edema has been observed and in young women the menstrual periods have been milder and shorter. These side effects are reversible, and patients receiving prolonged treatment should be examined and questioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time.

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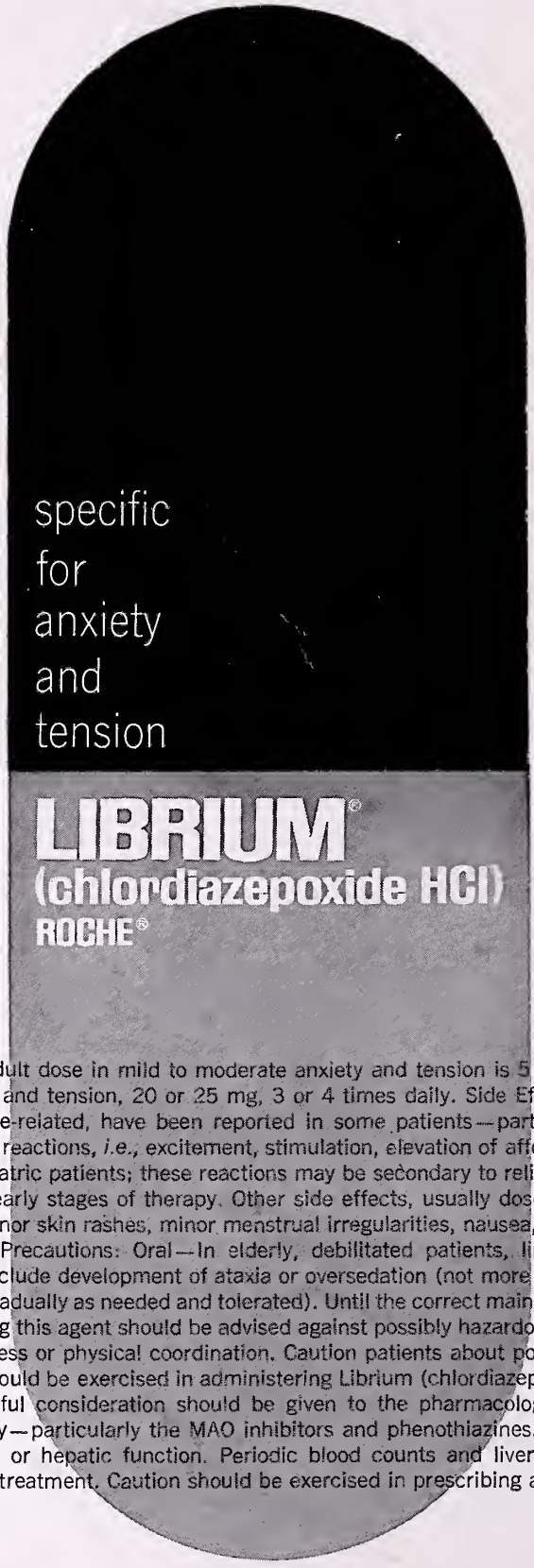
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V.16 #11

NOVEMBER ● 1963





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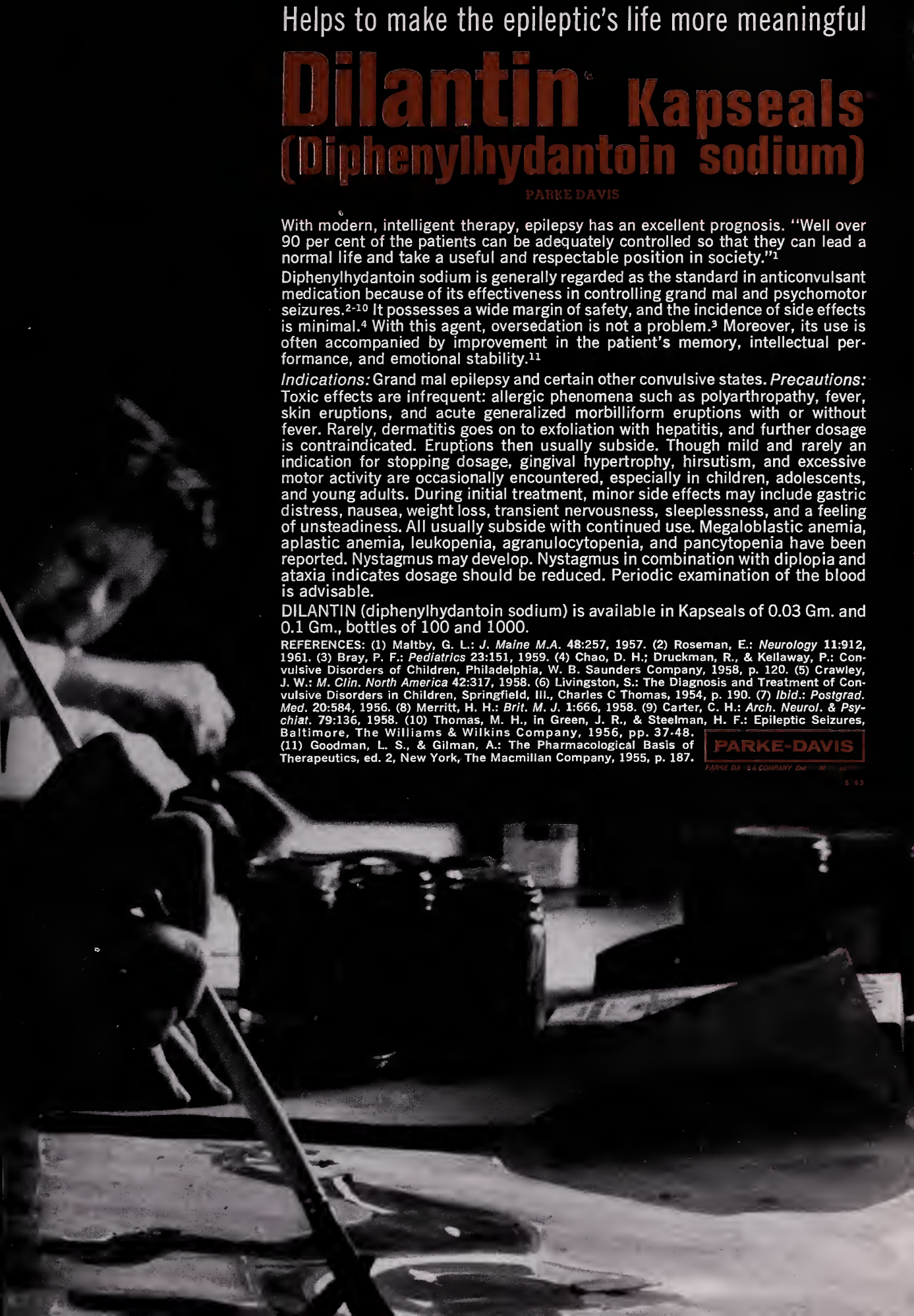
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Volume XVI **November, 1963** **Number 11**

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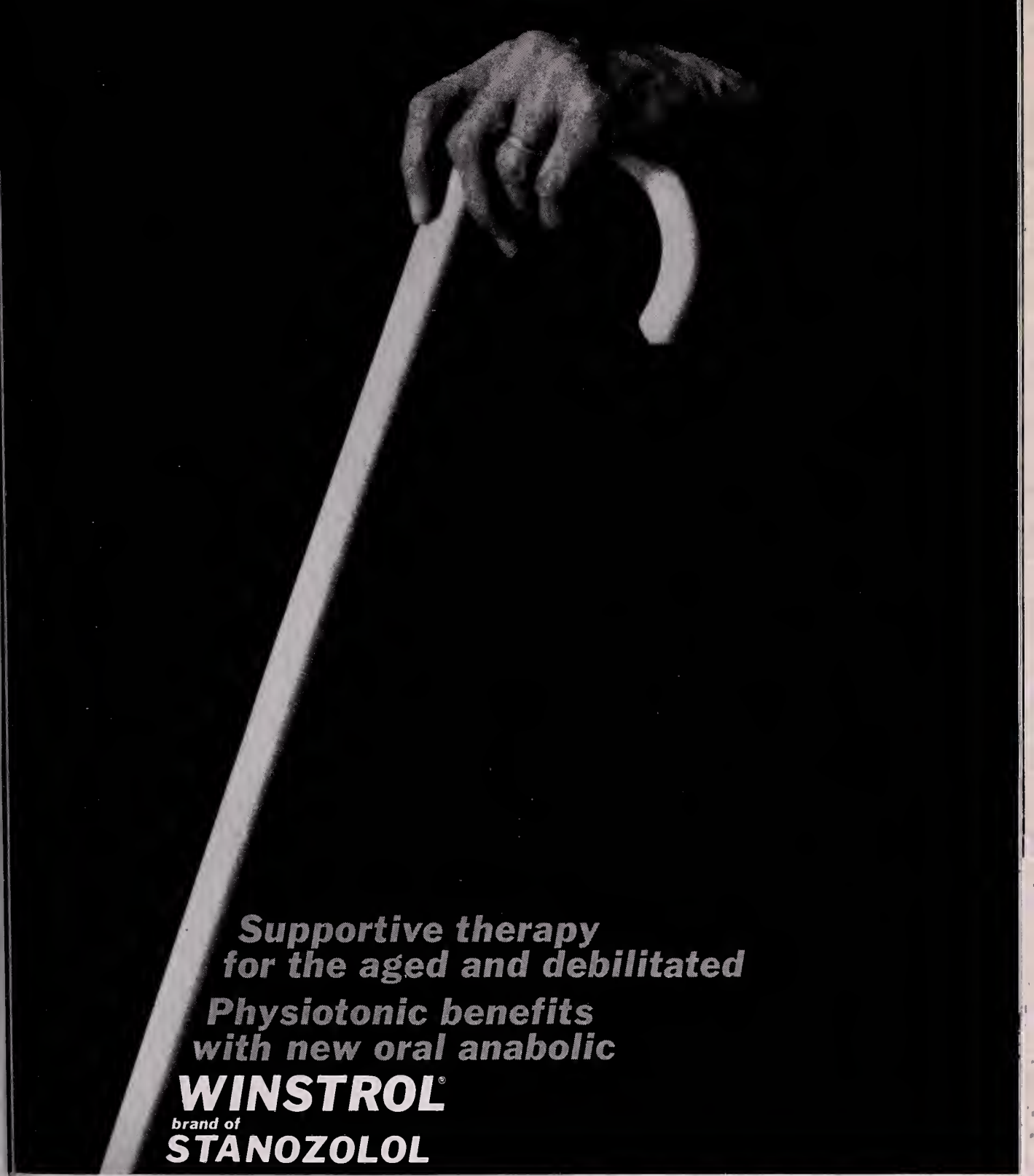
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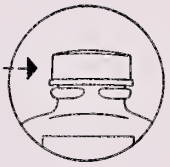
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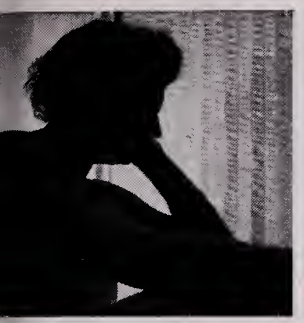
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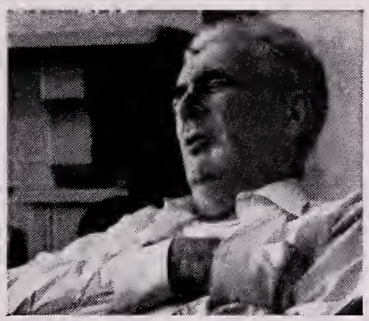
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The insomniac



The tense, nervous patient



The heart-disease patient



The surgical patient



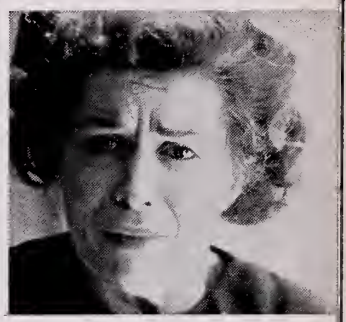
ıe girl with dermatosis



Tension headache



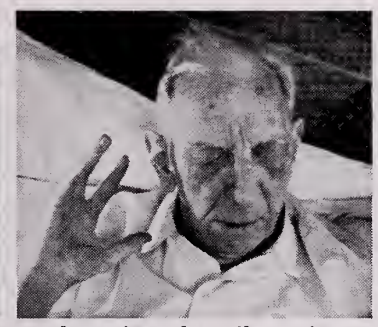
The woman in menopause



Anxious depression



'remenstrual tension



The agitated senile patient



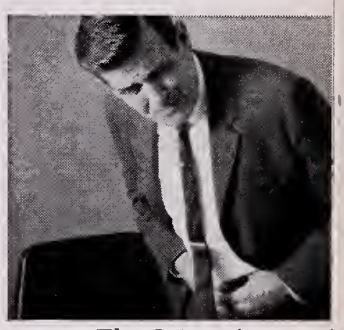
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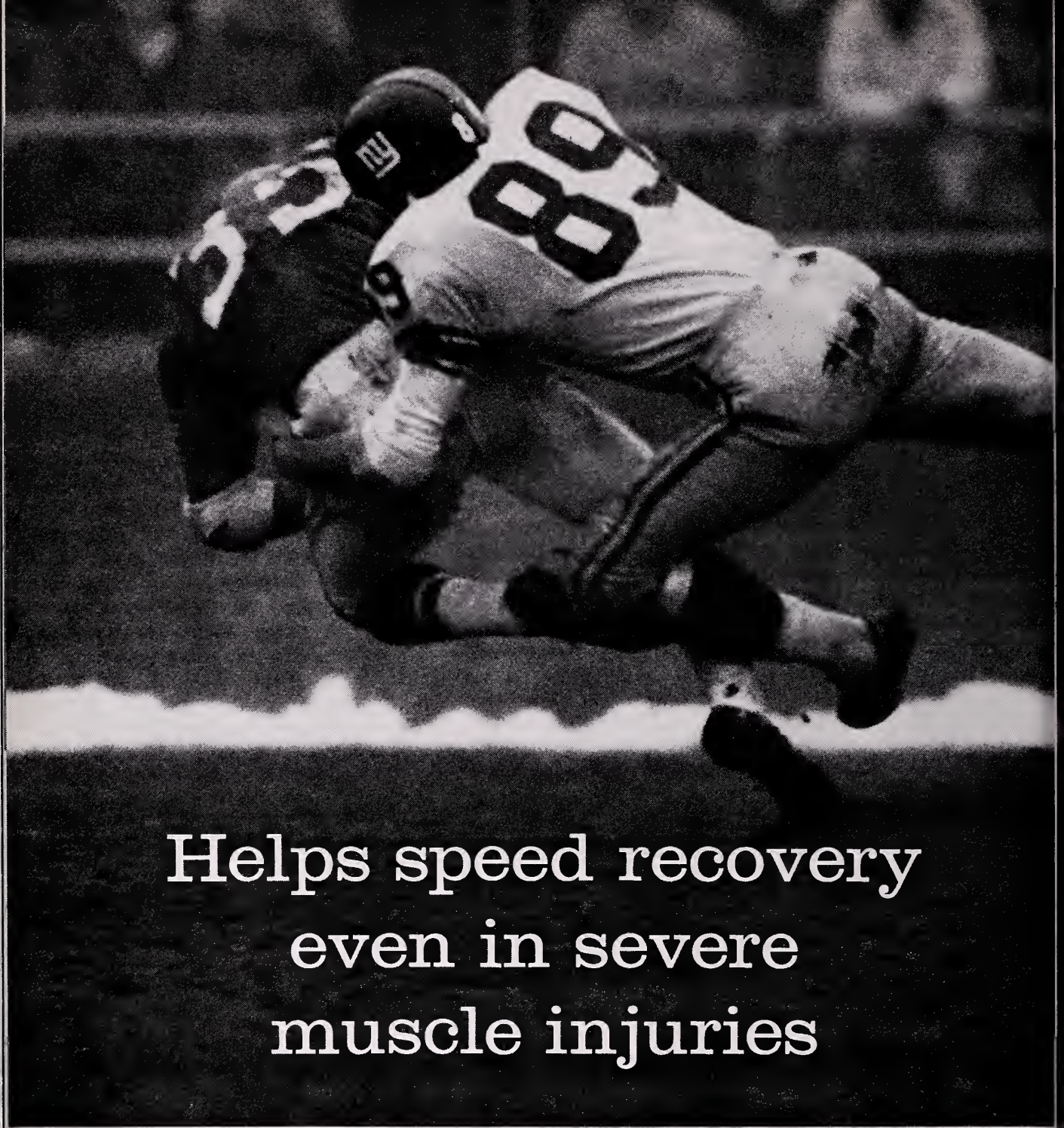


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Two new clinical reports document successful long-term treatment of ischemic heart disease with Persantin®, brand of dipyridamole

See next 3 pages

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Griep,A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:
A Report of Fifty Cases. Angiology 14:484, 1963.

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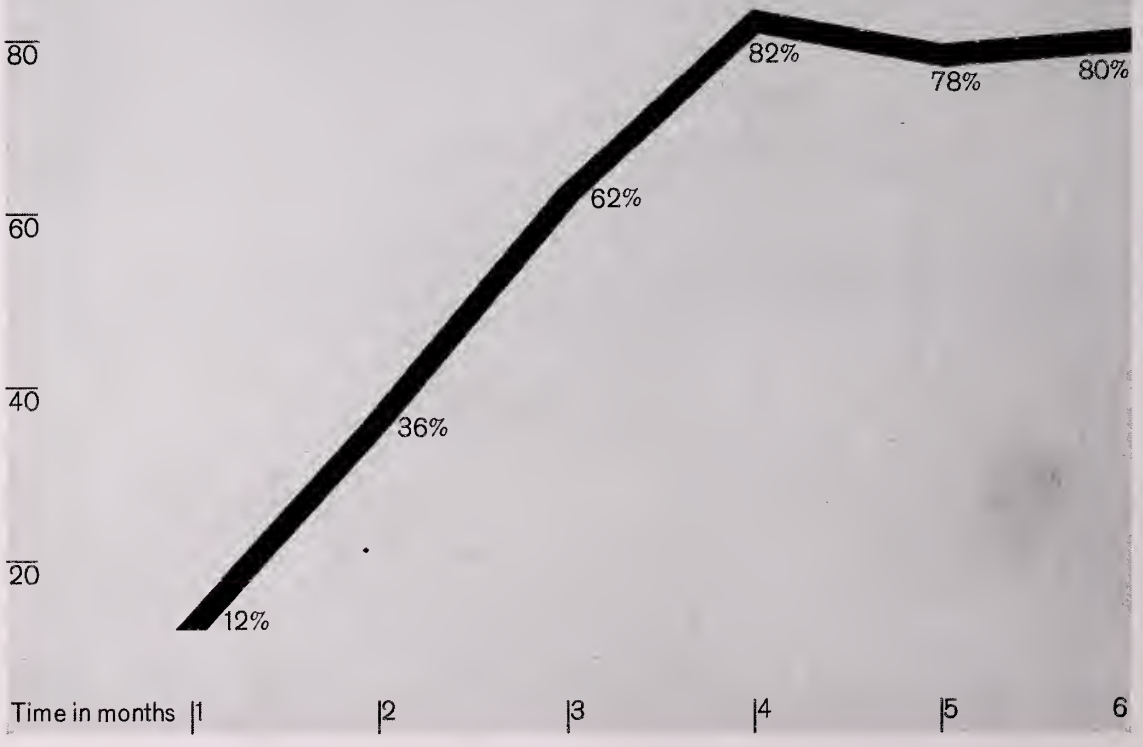
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"...long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients...

"relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"

% of patients responding each month to dipyridamole

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Study 2.
Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

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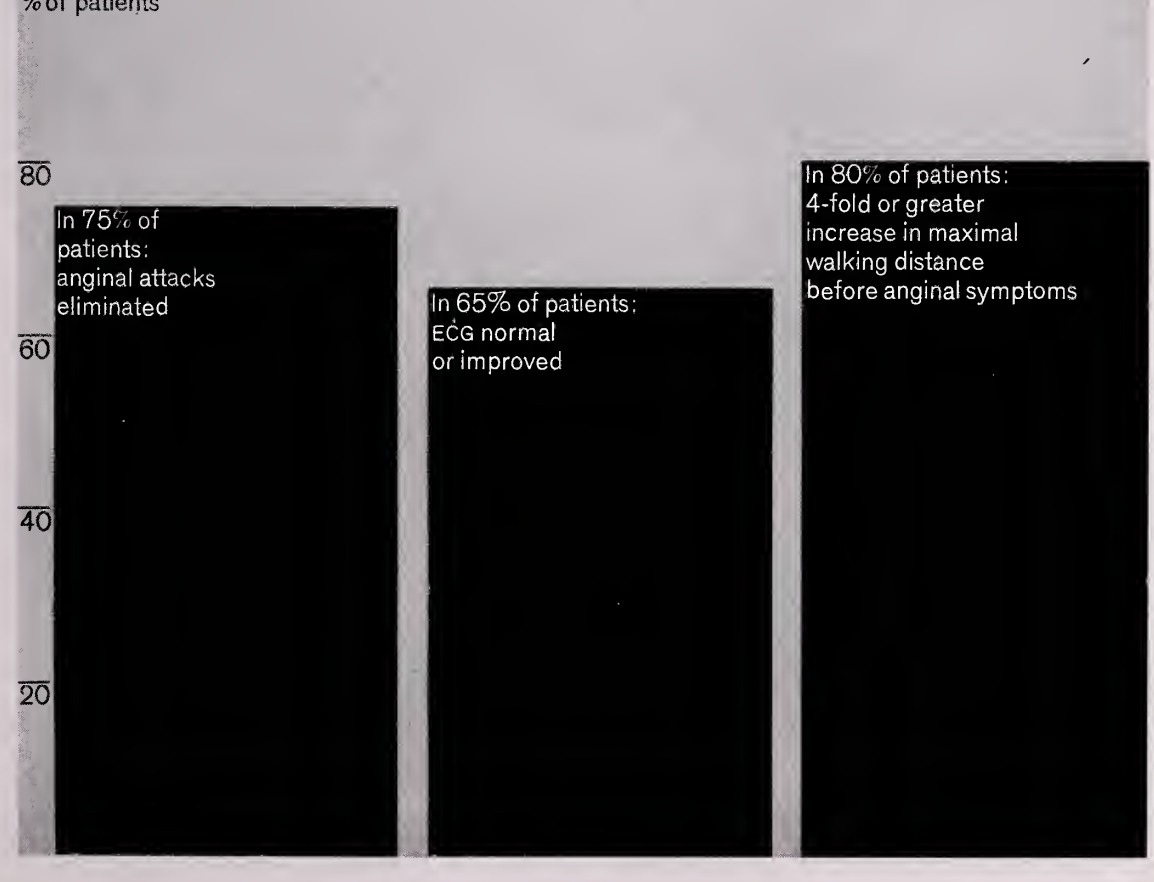
Geigy

After 3 months, 32 of 40 patients showed:

"...reduction or abolition of acute anginal attacks...

"complete or almost complete disappearance of ECG abnormalities...

"marked increase" in walking distance without anginal symptoms



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1. By increasing energy yield
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2. By improving collateral coronary circulation.
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When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:
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Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.,et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.26:849,1962.

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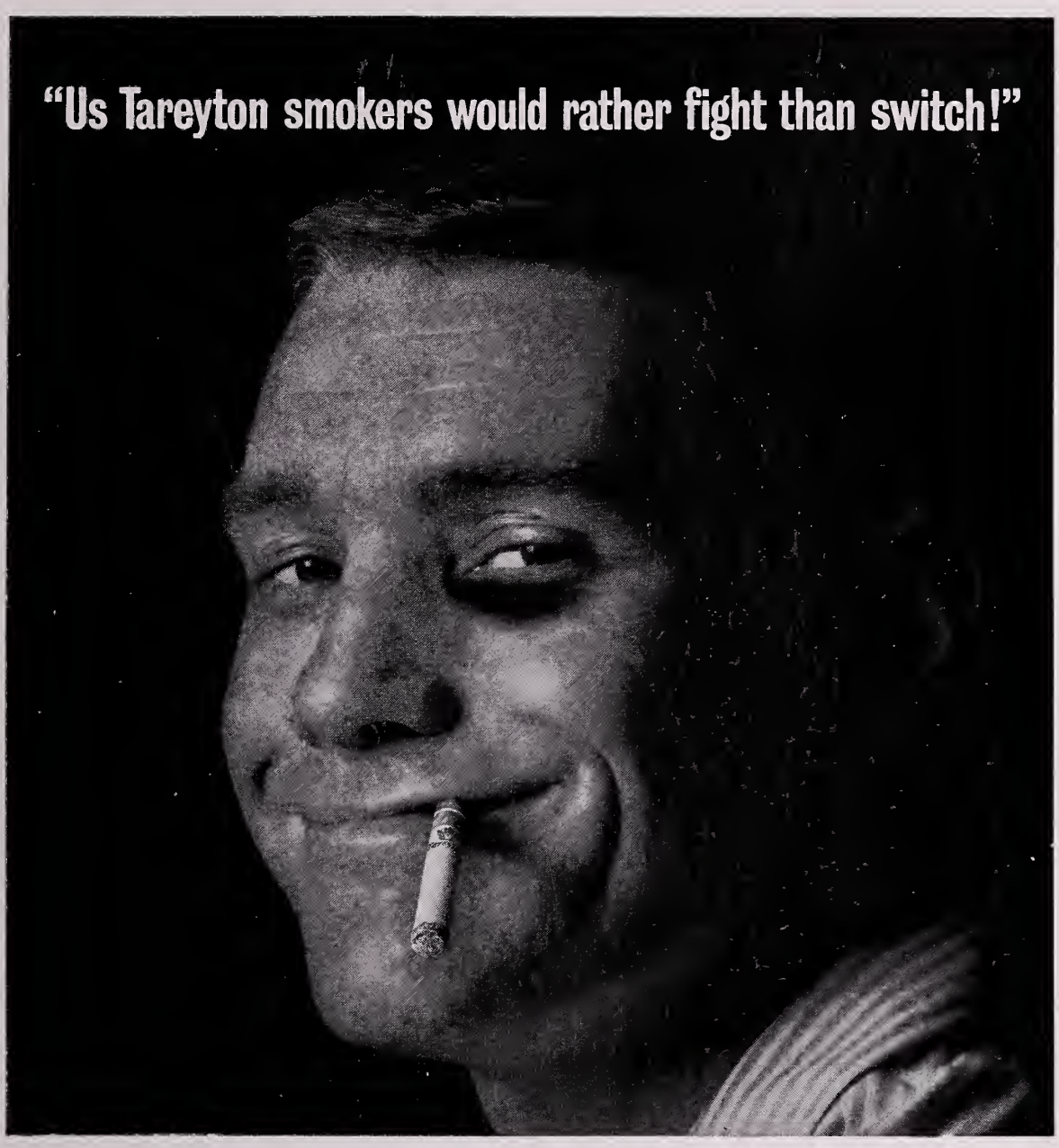
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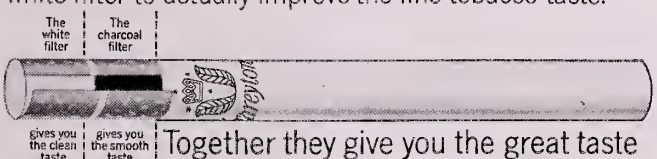
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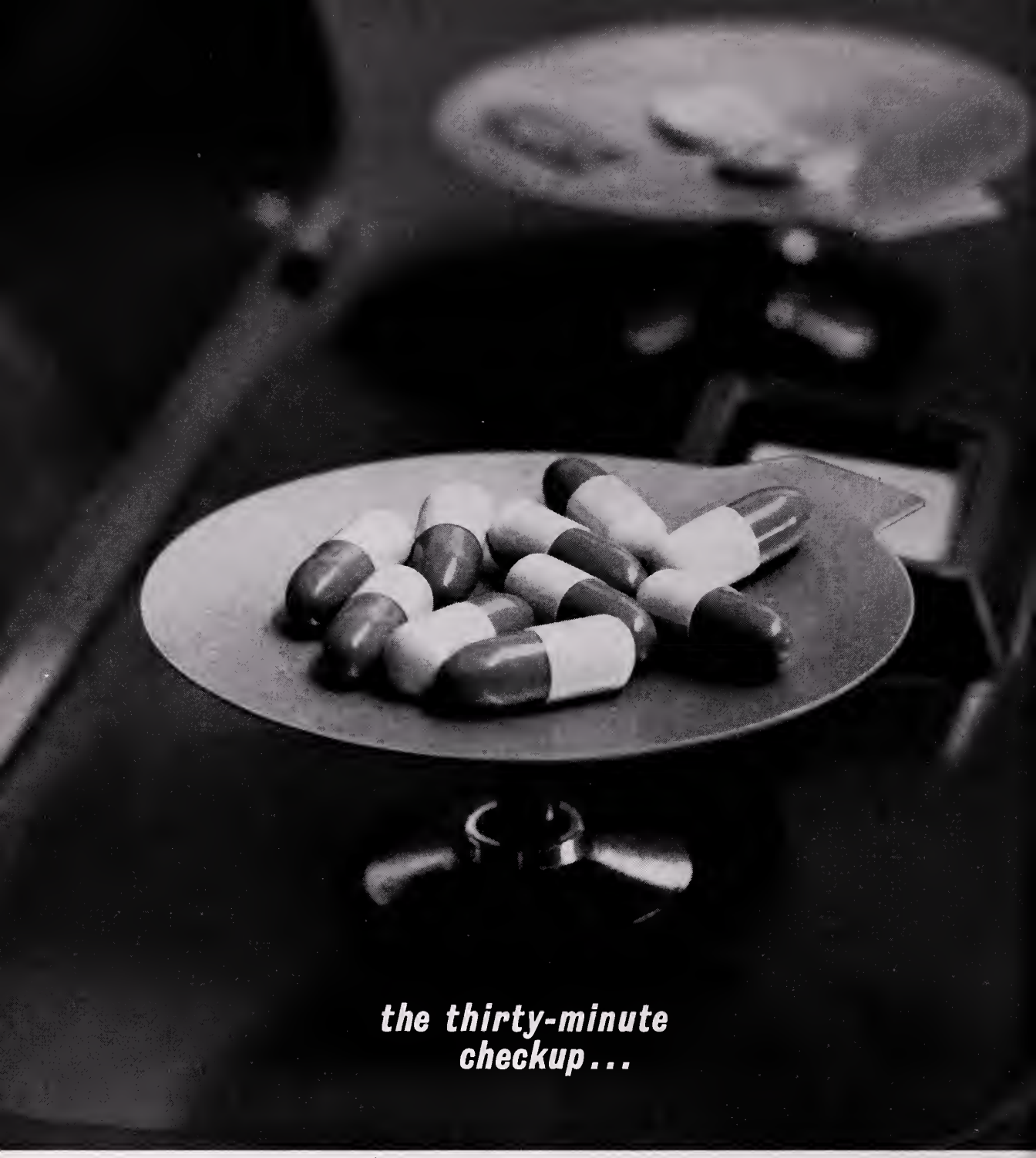


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Scientific PAPER

Paroxysmal Nocturnal Hemoglobinuria

Introduction

R. F. Thompson, M.D.
Yankton, South Dakota

Dark brown-black (coca-cola) urine often is the first and only manifestation of hemoglobinuria. If the hemoglobinuria occurs episodically during sleep, clearing later after awakening, paroxysmal nocturnal hemoglobinuria is suspected.* PNH is a rare, acquired, chronic, hemolytic disorder with persistent hemolysis; affects less than 2 per 1,000,000 population; was reported in over 200 patients as of 1960; has a variable course of remissions and exacerbations; and is compatible with long life. The basic defect resides within the red cell as it is produced in the bone marrow. The red cell is susceptible to rapid intravascular destruction by hemolytic factors present in normal serum (more will be said about this later). Such intravascular destruction produces hemoglobinemia (a plasma-free hemoglobin level above 25 mg.%), hemoglobinuria (when the plasma level exceeds the renal threshold), and hemosiderinuria. The renal threshold for hemoglobin tends to fall in the patient as the PNH persists; renal disease due to the hemoglobinuria is unknown.

Nocturnal or sleep backache, fever, muscular aches, and awakening hemoglobinuria result from increased hemolysis during sleep. The abnormally colored urine occasionally occurs many hours after awakening. The color is due to free hemoglobin. The same manifestation presents in any hemolytic disorder with rapid red cell destruction and hyperhemoglobinemia. A patient with a congenital hemolytic disorder rarely shows hemoglobinuria. Occasionally an acquired hemolytic disorder, such as idiopathic auto-

* Hereafter, PNH is used for Paroxysmal Nocturnal Hemoglobinuria.

YC #31165

LABORATORY DATA (SUMMARY)

Date	Hgb gm % a	Hgb gm % p	WBC N-L	Reticulocytes %	Platelets	Serum Bilirubin mgm %	Plasma Hgb mgm %	Ham's Acid Test / Crosby Thrombin Test	Blood Transfusion
1959									
March							81	HAT—neg. CTT—neg.	
June	8.6	10.6	4,000	7.1 12.9	55,000 79,000 74,000	1.7 1.5	77	Coomb's—neg. S. iron—122 mcg % Radiochromium tagged rbc life span: normal BUN—38 mg.%	
1960									
Jan. 26	13.8		6,300 56-43	3.6	178,000			HAT—pos.	20 units to this date
March 8	9.7		8,700 59-40	7.1	215,000	0.95	10		
June 7	8.2		5,250 57-42		174,000				
Sept. 13	8.3		5,500 75-22	0.6	172,250				
Nov. 18	7.3		6,800 81-19	1.5	286,000				
1961									
Jan. 24	6.5	10.1	5,100	10.0	91,000 171,000				3 units settled cells
March 14	6.5	9.8		5.8				S. iron—78 mgg % TIBC—382 mcg %	2 units settled cells

Figure 1

immune hemolytic anemia produces hemoglobinuria, hemosiderinuria, and methemalbuminuria.

The abnormally colored urine must be distinguished by appropriate testing from bile pigments, hematuria with hemolysis within the urinary bladder, ochronosis with alkaptonuria, myoglobinuria, porphyria with porphobilinuria, hematuria-albuminuria of poststreptococcal nephritis, and hemoglobinuria due to other causes.

PNH starts at any age, in any race. A "viral infection" usually precedes the onset, which suggests the possibility of the virus altering the production of red cells in the bone marrow. Leucopenia and thrombopenia often happen; PNH patients seem overly susceptible to infection; hemorrhagic complications are rare. Slight jaundice is chronically present; severe jaundice rarely. Cholelithiasis occurs at no higher incidence than normally.

Case Report

F.G.E., YC #31165, SHH #79121, birth date 1927, first developed left anterior chest pain, fatigability, and pallor in February 1959 at thirty-two years of age. The red blood cell count and hemoglobin were low and did not respond to Iron. He entered a hospital in March 1959 for studies. At this time he first noted dark brown-black urine, most prominent in the first morning voidings, nocturnal backache, occasional chills and fever, and progressive weakness and pallor. Whole blood transfusion intensified his symptoms.

In May 1959 he received washed rbc transfusions without difficulty. The diagnosis was hemolytic anemia with paroxysmal atypical nocturnal hemoglobinuria since the diagnostic tests were not positive. During the summer of 1959 he studied at Oxford University in England and noted only an occasional black-brown urine, and did not require any blood transfusions. Symptomatically he felt relatively well and returned to this country in the fall of 1959.

During December 1959 he developed a pharyngeal abscess which required drainage, progressive anemia, rather continuous hemoglobinuria, recurrent fever, backache, headaches, and generalized deep extremity aches. A ureteral blood clot responded to intraureteral flushing. Blood transfusions usually were followed by fever, chills, backache, headache, and increased hemoglobinuria.

Treatment prior to January 1960 included:

1. Corticosteroids.
2. Blood transfusions.
3. Miscellaneous medication (Pyridium, Aspirin, Codeine, Darvon) for pain.

From March 1959 to January 1960 he received 20 units of blood (either whole blood or saline washed cells). He tolerated the saline washed cells but had more pain, fever, and hemoglobinuria after each transfusion of whole blood.

Patient came under our observation in January 1960. Physical examination revealed no findings except slight scleral icterus without enlarged liver, spleen, or lymph nodes. Chest x-ray was repeatedly negative. (Laboratory studies are indicated in figures 1 and 2).

Treatment from January 1960 to August 1, 1962 included:

1. Corticosteroids.
2. Antacids and ulcer diet to control peptic ulcer symptoms.
3. Blood transfusions and Dextran infusions.
4. Medication: Warfarin Sodium, Fluoxymesterone, and Iron orally. (Figures 3 and 4).

Twenty-six units of blood were transfused from January 1960 to August 1, 1962. Initially the blood was allowed to stand 48 to 96 hours at four degrees Centigrade and the plasma withdrawn from the settled cells prior to transfusion; this procedure removed 80% of the donor plasma. He had reactions to most of these transfusions, depending upon the amount of residual plasma.

Starting January 1961 the patient received Dextran (mean molecular weight 75,000) prior to a transfusion in an attempt to reduce hemolysis after a transfusion of settled cells, or in the interval between transfusions. He received 1000 ml. of Abbott 6% Dextran on each of 2 days preceding 2 units of settled cells on January 24 thru January 27, 1961. (Refer to the chart for other Dextran infusions). Chest tightness, headache, fever,

YC #31165

LABORATORY DATA (SUMMARY)

Date	Hgb gm % a	Hgb gm % p	WBC N-L	Reticulocytes %	Platelets	Serum Bilirubin mgm %	Plasma Hgb mgm %	Ham's Acid Test / Crosby Thrombin Test	Blood Transfusion
1961									
Apr. 18	8.0								1 unit settled cells
May 23	7.1			6.5					1 unit settled cells
July 3	6.8	8.9		7.4					1 unit settled cells
Aug. 1	7.1	8.6							
Aug. 22	7.5	8.5		9.4					
Oct. 11	6.2	10.8	7,300 82-15	14.7				BUN—19 mg % Prothrombin—70%	5 units settled cells
1962									
Jan. 26	4.9	8.2		5.6				Prothrombin 8-35%	2 units settled cells
Feb. 2	8.2	13.2	9,800 72-27	0.2		0.88 S. uric acid 3.3 mg %		BUN—9.5 mg % TSP—6.5 gm % with abnormal B_2 globulin	3 units settled cells
Apr. 9	7.6	9.5		24 10				Urine Hgb/24 hrs —230 mg	3 units washed cells
June 15	6.4	10.5		4			118	Prothrombin 18%	4 units washed cells

Figure 2

YC #31165

BLOOD AND DEXTRAN TRANSFUSIONS

Date	Dextran mL—6 or 12%	Blood Settled Cells—Units	URINE			REACTION					
			Black	Brown	Clear	Fever	Chest tight	Tachycardia	Headache	Nausea	Backache
1961											
Jan. 24	1000—6%	0		clear		0	0	0	0	0	0
25	1000—6%	0		clear		0	+	+	0	+	0
26	0	1		clear		102°	0	0	0	0	0
27	0	1		black		0	0	0	0	0	0
Feb. 8	700—6%	0		decr.	black	0	+24 hrs.	0	0	0	0
15	700—6%	0		decr.	black	0	+24 hrs.	0	0	0	0
Mar. 7	0	1		black		0	0	0	+	0	0
15	0	1		clear		0	0	0	0	0	0
16	0	1		clear		0	0	0	0	0	0
Apr. 22	500—12%	1		clear		0	0	0	0	0	0
May 25	500—12%	1		clear		0	0	0	0	0	0
July 3	500—12%	1		0		0	0	0	0	0	0

Figure 3

YC #31165

BLOOD AND DEXTRAN TRANSFUSIONS

Date	Dextran mL—6 or 12%	Blood Settled Cells—Units	URINE			REACTION					
			Black	Brown	Clear	Fever	Chest tight	Tachycardia	Headache	Nausea	Backache
1961											
Aug. 3	500—12%	1	0			0	0	0	0	0	0
Sept. 5	500—12%	1	0			0	0	0	0	0	0
Oct. 12	500—12%	1	black			101°	0	0	+	+	+
16	500—12%	1	black			0	0	0	0	0	0
17	0	1	0			0	0	0	0	0	0
18	0	1	0			0	0	0	0	0	0
19	0	1	0			0	0	0	0	0	0
1962											
Jan. 26	500—12%	1	0			102°	+	+	+	+	+
27	0	1	black			102°	+	+	0	+	0
Feb. 2	0	1	0			0-chills	0	0	0	0	0
3	0	1	0			0-chills	0	0	0	0	0
7	0	1	0			0	0	0	0	0	0

Figure 4

nausea followed the second 6% Dextran infusion and transfusion 24 hours later was not associated with decreased hemoglobinuria. Monthly 12% Dextran (500 ml.), followed immediately by one unit of settled cells, was given from April 1961 to October 1961. Very little reaction followed the infusions, the hemoglobin remained relatively steady, and transfusion requirement did not decrease. In October 1961 he was transfused to a level of 10.8 gm.% hemoglobin and remained relatively well without further transfusions until January 1962 when the hemoglobin was 4.9 gm.% and transfusions were again given.

With the infusion of 12% Dextran (500 ml.) followed by 1 unit of settled cells on January 26, 1962, he developed fever, chills, tachycardia, chest tightness, nausea, headache, backache. At this point no further 12% Dextran was available and transfusions of settled cells were given without preparatory Dextran. Postinfusion there was less reaction except for occasionally a qualitatively increased hemoglobinuria, fever, and backache attributed to plasma infusion reactions. Since April 1962 he has received saline washed cells without any serious reaction post-transfusion.

During therapy with corticosteroids, which were initially tried since the hemolytic disease was atypical, no appreciable change in the hemolytic process was found. Peptic ulcer symptoms (relieved by diet and antacids), acne vulgaris, and mild obesity developed. Due to more undesirable than beneficial effects, this medication was discontinued in February 1961.

In October 1961 corticosteroids (Prednisolone) were again tried in doses of 120 mg. per day x 2 days, 80 mg. per day x 3 days, and 40 mg. daily for one month, and reduction to maintenance 10 mg. per day.

Approximately five days after the last Dextran infusion (January 26, 1962) he developed migratory joint aches, stiffness, swelling and local heat with slight fever, nausea, and generalized aches. This resembled an acute polyarthritis without skin eruption: the type seen with serum sickness reactions. L.E. cells were absent. He received increased Prednisolone (80 mg. daily), Compazine, Demerol, Salicylates, and Warfarin Sodium during this acute illness which dramatically responded within 48 hours. Reticulocyte count of 0.2% at this time suggested bone marrow aregeneration. However, reticulocytosis soon returned and there was no other evidence of aregeneration. The Prednisolone was decreased over two weeks to 10 mg. daily and discontinued on July 3, 1962. (Other laboratory studies showed an abnormal beta-globulin on paper electrophoresis of serum, TSP 6.55, albumin 4.3, BUN 9.5, serum uric acid 3.3 mg.%, serum bilirubin 0.88 mg.%.)

Maintenance oral Warfarin Sodium depressed the prothrombin activity to an average of 20% (range 8 to 35%) from October 1961 to July 1962 without definite improvement in the hemolytic disorder.

Because of a low serum iron, normal TIBC, and a bone marrow lacking in stainable deposited iron, he started Ferrous Sulfate on July 3, 1962. On the same date, Fluoxymesterone, 40 mg. daily (Halotestin, Upjohn) was started. (Refer F. Gardner, 1961.)

A severe hemolytic crisis started August 1962 and lasted five days. He received and accepted well three units of 4 times-saline-washed cells without incident. The crisis may have been related to increased emotional tension.

One episode of severe periumbilical pain, constant and colicky, lasting six hours occurred in 1961. No definite diagnosis was made: the pain has not recurred.

As of this date (January 1963), there has been no appreciable decrease in hemoglobinuria or transfusion requirements. Fluoxymesterone was therefore stopped. Transfusion of 6-times washed cells every six to twelve weeks allows a hemoglobin range of 5-6 gms.% to 10-11 gms.%. Many of the transfusions are followed within one hour by chills and fever up to 102°F., orally, lasting 12 hours. Occasionally the amounts of hemoglobinuria appear to increase immediately following transfusion for less than one day.

Discussion

In PNH the patient's rbc abruptly develops a lesion which makes the PNH-rbc susceptible to factors normally resident in plasma or serum. This change may occur suddenly, that is, be manifested abruptly; or produce minimal symptoms persistently; or with recurrent severe hemolytic crises. (Figure 5).

PNH — PLASMA FACTORS IN PNH HEMOLYSIS

1. Acidified serum (pH 6.7 to 7.1).
2. Inhibitory and Hemolytic factors (heat stable and labile).
3. Properdin (Zymosan extractable factor from C'3).
4. Ionic Magnesium.
5. Circulating Thrombin.

PNH - RBC ABNORMALITIES

1. Rapid hemolysis when transfused into normal person.
2. Sensitive to slight increases in temperature.
3. Abnormal cell stroma and wall morphologically; Chemically abnormal phospholipid and lipoprotein pattern.
4. Abnormal cellular metabolism; Reduced acetylcholinesterase; Abnormal phosphorus transport and phosphate turnover; Abnormal ATP stability.
5. Increased susceptibility to iso-antibodies, heterophil and auto-immune antibodies.

Figure 5

PNH-rbc transfused into normal patients, or other PNH-patients, or mixed in vitro with normal or PNH-serum (or defibrinated plasma) undergo rapid hemolysis. Acidified normal plasma or serum causes more rbc lysis; some anticoagulants (oxalate, citrates, and heparin in high concentrations) inhibit PNH-rbc lysis in vitro. Incubating PNH-rbc in its own defibrinated plasma at 37° C. for six hours (Hegglin-Maier test) produces hemolysis of the rbc; much more than any other situation except auto-immune hemolytic disease with warm antibodies in which situation the antibodies will lyse normal rbc (PNH-plasma does not).

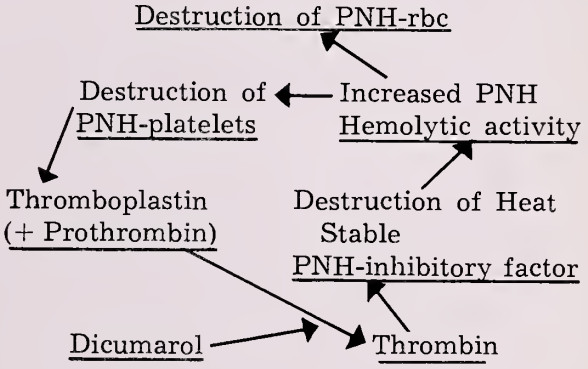
Normal plasma hemolyzes PNH-rbc in vitro and in vivo; plasma transfusions induce a fever and increased hemolysis and hemoglobinuria within six hours. Therefore, blood transfusions must be limited to washed-donor-rbc; washing as often as six times has been required in some patients to remove all donor plasma.

Hemolysis of PNH-rbc requires serum complement, magnesium ion in physiologic concentrations, pH 6.7 to 7.1, and properdin; this is the only naturally occurring hemolytic system requiring properdin. The PNH-rbc lytic activity of serum parallels the properdin titer of the serum (Hinz, 1954). (Properdin is a bactericidal factor extracted from the C'3 fraction of human and animal serum complement. Zymosan and other large molecule polysaccharides form complexes with properdin. Properdin can be reduced or eliminated from an animal's serum by infusions of a polysaccharide such as Dextran). Normal serum acidified to pH 6.7 to 7.1 and incubated with PNH-rbc produces increased amounts of hemolysis compared with the test done without acidification (Ham's acid test). Thrombin added to the acid serum mixture before incubation further increases hemolysis (Crosby, 1950).

Occasionally a prothrombin depressant drug such as Dicumarol decreases hemolysis; more frequently less pain occurs. Reduced pain may be due to decreased numbers of small thrombo-emboli.

Four factors exist in normal serum which have an effect on PNH-rbc: two hemolytic factors (one heat stable, the other labile); two protein factors inhibit hemolysis (one heat stable, the other labile). Thrombin rapidly destroys the stable inhibitory factor and increased hemolysis results. (Figure 6).

PNH Relation of Coagulation System and Hemolytic Mechanism



(modified from Crosby, 1953)

Figure 6

Thromboplastin devoid of properdin contamination will substitute for thrombin in the Crosby thrombin-acid-serum hemolytic test. Hemolyzed rbc have thromboplastin-like action; does the PNH hemolysis cycle perpetuate itself?

Electron microscopic studies show abnormalities in the wall of PNH-rbc; no other morphologic changes have been recorded unless iron deficiency develops. The patient's bone marrow is hyperplastic with normoblasts predominating; reticulocytosis and polychromasia occur in the peripheral blood unless an aregenerative crisis develops. There is a disturbed phospholipid and lipoprotein pattern in PNH-rbc.

The PNH-rbc chemical structure and metabolism (glycolytic enzyme activity, buffering capacity, hemoglobin electrophoresis, isoelectric point, etc.) are normal. However, most PNH-patients tested show reduced acetyl cholinesterase activity which is not correlated with severity of hemolysis. Also abnormal phosphorus transport, phosphate turnover, and ATP (adenosine triphosphate) stability occurs.

PNH-rbc show variable increased susceptibility to naturally occurring blood group aso-antibodies (A and B, not D), heterophil antibodies (to which normal rbc are only slightly sensitive), and auto-immune antibodies (such as are seen in acquired idiopathic hemolytic anemia) (either the cold or warm type).

The PNH-patient produces a mixture of normal and abnormal rbc; the % of abnormal red cells present determines the severity of hemolysis. Variations in plasma factors determine episodic hemolytic crises, changes in hemolytic activity during sleep, and other short term variations (Crosby, 1953). During aregenerative crises, which may occur in any patient, transfusion requirement persists or increases; but hemoglobinuria, hemosiderinuria, and reticulocytosis decrease or disappear. (Hemosiderinuria persists until all the renal epithelial cells containing hemosiderin are shed, which requires considerable time, and the aregenerative crisis has often passed before hemosiderinuria ends.) The degree of anemia usually reflects the degree of hemolysis. RBC life span studies in PNH-patients suggest that many have a relative bone marrow failure, although morphologically hyperplastic. (Thus, PNH resembles PA?)

Leucopenia frequently occurs with counts of 3,000 to 5,000 per cmm. Leucocytic response to infection is less than expected normally. Intracellular alkaline phosphatase is low.

Platelets are usually lower than normal; megakaryocytes seem to be normal in number and function. (Figure 7.) In vitro studies indicate increased PNH-platelet agglutination when exposed to acidified PNH or normal serum or plasma; increased agglutination occurs when thrombin is added to the acid-

PLASMA FACTORS IN PNH HEMOLYTIC SYSTEM

	Water Solubility	Heat Sensitivity	Action of Thrombin	Co Factors
1. Hemolytic factors				
a. Heat labile	soluble	inactivated 53° C-10 min	inactivation slowly=100 U/ml - 37°C rapidly=200 U/ml - 37°C	requires heat stable hemolytic factor
b. Heat stable	insoluble	resistant	resists 100 U/ml	requires heat labile hemolytic factor
2. Hemolytic inhibitory factors				
a. Heat labile	insoluble	inactivated 53°C-10 min	resists 100 U/ml	none
*b. Heat stable	soluble	resists 53°C-30 min	inactivated 100 U/ml 53°C-10 min	none

Figure 7

serum. Platelet function as measured by thrombin generation and clot retraction is normal. (Flexner, 1960.) Decreased platelet agglutination in vitro and elevated platelet counts follow treatment with prothrombin depressant drugs (specifically Dicumarol). (Crosby, 1953.)

Many relatively innocuous drugs and chemicals in a particular patient may increase the hemolysis. Infection, trauma, fatigue, intense emotion, and occasionally food ingestion frequently trigger a hemolytic crisis.

Two factors control Hemoglobinuria:

1. The amount of hemoglobin released intravascularly per unit of time exceeding that catabolized elsewhere.
2. The "renal threshold" of hemoglobin.

Free hemoglobin in the plasma combines with a mucoprotein forming a complex. Excessive free hemoglobin causes saturation of the available mucoprotein. The hemoglobin-mucoprotein complex is cleared from the plasma without being excreted, and excess free hemoglobin is excreted in the urine. The available plasma mucoprotein decreases with chronic hemoglobinemia. Thus in PNH, hemoglobinuria occurs at lower levels of plasma hemoglobin than normally expected. (Wagley, 1958). Hemoglobinuria persists throughout the day whenever the hemolytic process is severe. Urine hemoglobin is always only a small part of the total released by the destroyed red cells. (Crosby, 1953).

Hemosiderin is found in the urinary sediment (intracellularly and extracellularly) and the renal tubular cells; the tubular cells slough when loaded with hemosiderin. There is very little in the spleen and liver as in other hemolytic anemias. Transfusion siderosis may occur due to the great number of transfusions usually received by a patient with PNH. Hemosiderinuria occurs in any patient with a high or persistently elevated plasma hemoglobin level. It is not pathognomonic for PNH; and may be absent for a prolonged period in PNH.

Renal tubular cells actively reabsorb hemoglobin from the glomerular filtrate and split the molecule: porphyrin fractions enter the blood; globin returns to the blood or enters the tubular filtrate; the iron returns to the plasma as ferritin or deposits within the renal tubular cells and the cells later slough causing the hemosiderinuria. Although iron loss into the urine is considerable, the PNH patient usually has received sufficient blood transfusions to compensate for the loss.

Laboratory tests for diagnosis:

Anemia, reticulocytosis, hemoglobinuria, hemosiderinuria, hyperhemoglobinemia establish the diagnosis of chronic hemolytic disease with hemoglobinuria. RBC fragility tests (osmotic and mechanical) are normal. The peripheral blood smears show relatively normocytic normochromic cells, variable hypochromia, polychromasia and reticulocytosis; no spherocytosis, fragmented red cells, or sickle cells.

Special tests include: hemosiderin in urine, heat sensitivity of red cells, acid-serum hemolytic test of Ham, thrombin-acid-serum hemolytic test of Crosby. Also, if the red cells lyse when exposed to complement, purified properdin, pH 6.7 to 7.1, and magnesium ion, the patient has PNH.

Complications:

There is an increased incidence of peptic ulcer, pyelonephritis, and thrombo-embolic complications. Leucopenia, agranulocytosis, and infection may occur; the degree of leucopenia correlates well with the severity of the hemolytic process. Thrombo-embolic complications cause much of the pain seen in PNH. Dicumarol may prevent thromboses, decrease pain, impede hemolysis, and inconsistently affects the anemia. If Dicumarol is discontinued, hemolytic crisis may occur.

Treatment:

1. Saline washed rbc with or without pre-transfusion Dextran.
2. Androgens, pharmacologic doses: Fluoxymesterone, 30 mgs. daily, orally, Testosterone propionate 1.0 gm. I.M., weekly.
3. Prothrombin depressant drugs (Dicumarol, Warfarin).
4. Avoidance of drugs, trauma, infection, emotion, fatigue, and idiosyncratic foods.

Saline washed blood cells per transfusion as required to maintain the hemoglobin at a satisfactory level is the mainstay of treatment. Intermittent transfusion to produce a hemoglobin of 12.0 to 13.0 gms.% may be associated with less transfusion need than monthly transfusions to maintain a hemo-

globin of 8.0 gms.%. Removing all of the donor plasma by washing the cells, as many as six times if necessary, prevents hemolysis of the patient's red cells by the donor plasma. Preceding the transfusion with high molecular weight dextrans probably produces properdin-dextran complexes and inhibition of the PNH-hemolytic system. (British Glaxo has m.m.w. 150,000 compared with American dextrans of m.m.w. 75,000). Dextrans do not prevent the febrile reaction from buffy-coat cells which may remain with the settled or washed cells. Although the cells in a bottle or plastic bag of whole blood remaining 24 to 72 hours at 4°C. will settle and allow 80% of the plasma to be removed before transfusion, the buffy-coat remaining usually causes a febrile reaction, and the small amount of plasma infused causes a plasma transfusion reaction. Pretransfusion infusion of dextran will decrease or eliminate only the plasma transfusion reaction. (Crosby, 1953) (Gardner, 1960).

Androgens in pharmacologic doses administered at least for six months have decreased transfusion requirements in some patients by apparently stimulating the bone marrow (increasing the relative number of stem cells producing and releasing red cells). This patient thus far responded negligibly. (Gardner, 1961).

Prothrombin depressant drugs merit a trial. In this patient, transfusion requirement remained the same but pain may have decreased. Hemolysis possibly was more severe after the Warfarin was stopped.

Patients must avoid drugs and chemicals of any kind since many cause hemolytic crises. Trauma, infection, emotion, fatigue, and idiosyncratic reactions to certain food occasionally precipitate hemolytic crises. No relationship has been shown in this patient for these factors.

Repeated dextran infusions may stimulate an antibody response, and serum sickness reactions may follow consecutive courses of therapy. (Treffers, 1958). This undoubtedly occurred in this patient, although we have not attempted to prove it by readministration of dextran. Prednisolone therapy apparently blocked the antigen-antibody response, reduced the capillary permeability, and inhibited inflammation until the offending antigen (dextran) was eliminated by the body.

Prognosis:

1. Spontaneous remission after several years.
2. Continuing hemolytic disease of variable severity for many years.
3. Complications:
   a. Aregenerative bone marrow crises
   b. Agranulocytosis and infection
   c. Thrombo-embolism
   d. Iron deficiency
   e. Transfusion siderosis
   f. Pyelonephritis
   g. Peptic ulcer

The course of the disease in each patient varies from time to time, and from patient to patient. PNH is compatible with long life when transfusions are given to maintain satisfactory hemoglobin levels. Spontaneous remission may occur after several years of severe hemolysis and hemoglobinuria; at such times no evidence of abnormal red cells can be found on testing. Remission and relapses depend upon the relative number of abnormal red cells produced by the bone marrow. Pregnancy may or may not be associated with a remission or decreased transfusion requirements.

An aregenerative phase rarely lasts longer than a few months. Severe complicating infection may result from individual white cell abnormalities or decreased numbers of white cells. Thrombo-embolic disease rarely occurs, is probably related to abnormal platelet agglutinability, and may affect the arterial or venous system in any part of the body. Iron deficiency due to large urinary iron losses rarely occurs in patients who have been transfused as needed. Oral or parenteral iron may exaggerate the hemolytic process and therefore is avoided unless needed. Transfusion siderosis has never been a problem but is a possibility. Recurrent pyelonephritis with eventual uremia occurs more often than normally expected.

Summary

PNH is a unique acquired hemolytic disease with:

1. Abnormal red cells; normal serum.
2. The origin and kind of red cell abnormality has not been fully elucidated.

3. There are no antibodies in the patient's serum which hemolyze his red cells.
4. Why hemolysis varies from time to time is unknown.
5. Hemolysis in vitro requires the Properdin system and an optimum pH.
6. Hemolysis in vivo probably is the same as in vitro.

A patient has been presented who demonstrates some of the problems involved in diagnosis and management of PNH.

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(Continued on Page 44)



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Clinical Correlation of Stomach-Bowel Difficulties in People With Depressions*

by

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The association of intestinal stasis and resulting constipation with depressions has long been recognized. However, medical literature ignores a host of other symptoms, most of which are related to the digestive system, seen with great frequency in depressed patients. This presentation points out this apparent relationship.

Patients who had been hospitalized in the psychiatric division of Methodist Hospital in a six-week period were screened in order to find those whose predominant clinical feature was depression. All were in-patients of a single practitioner. Of the total twenty-eight patients for this period, nineteen or sixty-eight per cent were hospitalized for treatment of affective reactions. This illustrates the frequency with which various sorts of depressions are encountered as psychiatric problems, at least in this area of the midwest. The symptomatology is described at the time that each patient enters the hospital, the time of the most severe state of depression. From our experience, as well as in the cases presented, the symptoms are the most severe during the height of the depression, contrary to the commonly stated observation that gastro-intestinal symptomatology improves as the depression worsens.

In addition to gastro-intestinal symptoms, the most commonly encountered complaints

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in these patients are early morning awakening with insomnia, fatigue, and tension type headache. (See chart). The least common somatic complaints encountered include urinary frequency, biliary dyskinesia, anginal chest pain, lumbar backache, and paresthesias. None of these complaints was offered by more than two of the total number of patients studied.

The gastro-intestinal complaints can best be grouped into three levels, each denoting involvement of principally one segment of the intestinal tract. One, two or all three levels may be involved simultaneously but often the demarcation is apparent. The first level involves that portion above the pylorus; patients whose complaints include anorexia, nausea, and/or vomiting are grouped at this level. The second level overlaps the first somewhat into the stomach and extends into the duodenum. Complaints include hyperacidity, gastro-duodenal colic, and hyperactivity, the triad of duodenal ulcer. The final level involves the lower bowel and includes complaints of intermittent diarrhea and constipation, intestinal colic, and flatus, comprising the functional bowel syndrome.

Each patient's history was abstracted from the original case record as given on admission. Several of the patients were then reinterviewed for the purpose of making a short mental examination, and specific inquiry was made regarding the eating habits, their opinion regarding the food, indigestion, bowel habits, the use of laxatives, and the occurrence of diarrhea. Of the nineteen patients placed into the depressive category, all had upper gastro-intestinal symptoms; one hundred per cent showed first level complaints of anorexia, nausea, or vomiting, and fifty per cent had second level complaints of hyperacidity or duodenal ulcer. Twenty-six per cent had lower bowel or third level complaints comprising the functional bowel syndrome. In a study by Friess and Nelson,[1] on the other hand, only forty-one per cent of neurotic patients had gastro-intestinal symptoms as a complaint. No correlation was found between severity of depression and level of gastro-intestinal localization.

We are not classifying our cases according to diagnostic categories, but on the basis of the psychological content of their symptoms. The great majority were affective reactions, either involutional psychotic reactions, manic depressive reactions, depressed type, or psychotic depressive reactions. All were, then, endogenous introjective type reactions. This broad categorization allows more conclusive results regarding the question of functional gastro-intestinal difficulties.

The following cases are illustrative.

Case 1.

A slim, good-looking, but "whiny" fifty-two-year-old married woman, essentially well until June, 1960, complains of feeling depressed and an inability to sleep or eat. She expresses suicidal tendencies and thinks that her husband isn't good to her and doesn't love her. These complaints of about one week's duration came shortly after she had moved from another town, leaving all her friends and acquaintances, in order to be with her husband, a confirmed drunk. On admission, the patient complained of anorexia and weight loss, "knotting" of her stomach accompanied by "burning" pain especially at her meals and at night. "My stomach burns often and awakens me at 2:00 or 3:00 A.M.; if I take soda and water, I feel better after belching a few times."

Her condition improved slightly with psychotherapy and medication but in July, 1961, she suffered a very severe depressive reaction characterized by anorexia, nausea, vomiting, weight loss, diarrhea with intermittent constipation, insomnia and suicidal desires. Her husband had been staying out late, drinking excessively, stumbling around the home at night, and verbally "railing" at her. She showed little improvement and was

admitted for psychiatric treatment in August, 1961. Gradual improvement was noted in the next four weeks when she suddenly suffered an acute bowel obstruction and underwent surgery for an obstructive carcinoid lesion of the ileum. Recovery was satisfactory and she returned to her unhappy home situation.

In March, 1962, her symptoms of nausea, weight loss, crying spells, early morning awakening and light-headedness returned, but improved somewhat with hospitalization and psychiatric care. Since that time her reactive depression and gastro-intestinal complaints have gradually reappeared since her chief hostility is her husband's continued alcoholism for which no satisfactory answer has been found.

Physical Examination and Laboratory Studies. The general examination disclosed no evidence of organic disease or recurrence of the carcinoid tumor. Gastric studies disclosed no abnormalities. Neurologically she is entirely normal.

LIFE SITUATION

The patient was the third born of nine children reared on a farm in a rural community. Her father, still living at the age of eighty, was extremely stern, rigid and penurious, did not accept any of the children and treated his wife badly. Her mother, now seventy-seven, was a very ineffectual, anxiety-ridden person, overwhelmed by the housework and care of nine children. When the patient was sixteen years old, she had a toxic thyroid adenoma and exhibited all the signs of a toxic hyperthyroidism characterized by anxiety, palpitation, and profuse sweating. Her father, however, refused to take her to a doctor. She gradually became so ill that her mother's brother took her to the physician and paid for the surgery. The rejection of her "stingy" and tyrannical father resulted in the development of her hysterical personality and insecurity. The patient's verbal reiterated epitomization is, "I always wanted love and approval from Pa, Doc, but I just didn't get it."

She was graduated from high school and married at the age of twenty-two. The marriage was satisfactory until about ten years ago when her weak husband began to "tipple and topple." They have two sons, the older of whom is in the army and the younger entering into college. The patient has transferred much of her affection and energies to her sons and in return demands their affection, but she has taken an "I don't care" attitude with her husband. He was recently fired from his job in a department store for embezzling funds. We are speculating that the patient and her husband are both hysterically weakly charactered. Both are demanding of love and affection. In their dependent "leaning" upon one another, the "hubby" has gone down the alcoholic drain helplessly, while the patient has tried to battle the threat of life's drowning flood.

This hysterical personality, developed from an unhappy childhood, along with compulsive, battling compensations, has made the patient unable to adjust to her problematical husband. Unable to obtain the attention from him that she desires, the feminine role responsibilities as a wife and mother have been very difficult for her. She is admittedly rather a martyr, but exhibits also a poor social adjustment. She typifies the introjected, chronic complainer and tends to overindulge in self-pity. She has "swallowed" her poisonous husband, giving her not only "psychological strychnine" cramping, but also severe guilt. Moving from one town to another was the precipitating trauma which necessitated responsibility changes that disturbed her sense of security in relation to other people. Stoeckle and Davidson[2] point out that such traumatic experiences cause the patient to feel unjustly treated. Here, this "injustice," real and/or imagined, was done by someone very close to her, her husband.

Case 2.

A 73-year-old retired farmer complains of feeling "sick to my stomach," agitated, irritable, and depressed for the last thirteen months. This started in the spring of 1961 when he noticed difficulty getting his farm work done. He said, "I just worked in the fields from morning 'til dark like my father and when I finished the day, I thought that I could have done a lot more." A conscientious and compulsive worker all his life, this worried him and he soon felt run down, anorexic, and became over-concerned with his bowel function. Laxatives became a daily habit. One day while farming, a sudden oppressive, squeezing feeling in his chest with acute generalized weakness overcame him. Frightened, he rushed to the hospital but a thorough check-up revealed no physical abnormalities. In the next few months his condition did not improve and he was hospitalized five times for observation. He was extremely depressed, couldn't sleep and was under sedation much of the time. The patient and his doctor decided that, due to the patient's age and ill health, he should retire. Following this his condition improved for a few weeks, but he soon became depressed, paranoid and anxiety-ridden. Somatically, he complained of anorexia, nausea, burning stomach pain, constipation and fatigue. He was treated by numerous physicians and in October, 1961, spent two weeks in a large medical center for study and evaluation, but nothing positive was found. In December he was sent to another large medical center when the stomach pain became severe. A non-functioning gall bladder was found and he underwent cholecystectomy and appendectomy. However, postoperatively the symptoms worsened, he became disappointed, depressed, and irritable and would often pace the floor wringing his hands. He felt mistreated by his family, was very uncommunicative, couldn't sleep or eat, and expressed suicidal tendencies. In April, 1962, he was hospitalized for psychiatric care and was convinced he had some dread disease, such as cancer. Gradual improvement was noted and he was released after five weeks, but continues to return weekly for outpatient care. He remains mildly depressed and over-concerned with his bowel function, offering various gastro-intestinal complaints from day to day. Having developed no hobbies or interests outside of his farming, the patient becomes very anxious and depressed when he is inactive.

Physical Examination and Laboratory Studies. The patient is a small balding man who appears in good physical condition for his age, but is very depressed and agitated. No evidence of organic disease is found. Laboratory studies are within normal limits. Neurologically he is normal. Past health has been excellent except for frequent bouts of diarrhea under stress.

LIFE SITUATION

The patient is one of six children born and reared on a farm in Denmark. Although their childhood was a happy one, all were required to work hard on the farm. His mother died in childbirth when the patient was ten years old, and his father later remarried and had more children. After the eighth grade he quit school and worked as a farmhand. In 1914 at the age of twenty-seven he emigrated to the United States with two of his brothers and they settled down on farms in Iowa. At the age of thirty-five he married a woman nearly twenty years younger than himself. They have been happily married and have five children, all of whom are married and four of whom live on farms within a six-mile radius of the patient. He enjoys frequent visits from them and his grandchildren. Upon retiring he turned over his farmland to one of his sons. He and his wife presently live alone on the farm and busy themselves to some extent with a large garden.

Confronted with a loss of vigor and ability to work due to his advancing age, the pa-

tient's compulsive defenses are torn down, resulting in depression. His "forced" retirement lowered his self-esteem still further, and his functional complaints, at first centered on his heart, settled in the digestive system. Medical treatment fails to replace his lost status and finally surgery removes his concept of super-masculinity which he has enjoyed as an expert farmer. Role change compounded by bodily loss through surgery served as the precipitating event.

The history also illustrates the long period of time before the patient's true condition was recognized. Depressed persons, because of their hard-working, perfectionistic nature, are able to put on a good "front." Because they hate to face the day and then improve as the day goes on, they are "found out" more easily in the morning than in the afternoon or evening; this is known as diurnal variation. Checking with the family is important in order to discover the patient's difficulties. Even so, often the patient in his domination of the family has them under his control and they become his allies.

Medical confreres are embarrassed daily when close friends and family kill themselves under their very noses; such a mishap was a possibility in this case. Careful questioning regarding suicidal intent in a person who is "just a little blue with some difficulty in eating," is very revealing. The questions, "Is life worthwhile?" "Can you understand how people may kill themselves when very blue?" and "Have you ever thought of doing away with yourself?" are not crude but, rather, sophisticated. This possibility of suicide is of prime importance in the "hidden depression" referred to by Waggoner[3], who emphasizes that inappropriate treatment of the apparent physical disease can be harmful to the patient.

Case 3.

The patient, a self-centered, polite housewife of sixty-nine years, was admitted for psychiatric treatment of an agitated depression in March, 1962. She has been treated for similar depressive episodes in 1941, 1953, 1956, and January 1962. With each of the last two episodes she has shown similar somatic complaints of constipation, flatulence, abdominal pain, spasm and anorexia, comprising a full-blown functional bowel syndrome. She is also bothered with insomnia, and expresses suicidal trends.

Behind this overly sweet woman lies overwhelming hatred and frigidity. Her present conflict was precipitated by her concern about an older sister who is quite ill and is becoming senile. Recently the sister has wanted to come and live with the patient and her husband, saying, "Your house is as big as a church and I think it is too bad you don't have room for your sister." Two younger widowed sisters are taking care of this sister at the present time but would like to be rid of the responsibility. The patient is torn by the conflict of feeling obligated on the one hand, and incapable and unwilling on the other.

She expressed, like many elderly, proper ladies of our time, "That every day is like every other day"; this sameness of every day emphasizes her life of quiet desperation. Proper automata of Victorian life was her rule and guide; she related to things rather than to people and so, like the Mad Hatter in Alice's tea party it was always tea-time because it was four o'clock. She continued to show a narcissistic over-concern with her body functions and bored others with polite small-talk of her symptoms. She could do the proper automatic things in life but hadn't enough love for her sister; she had "run out of love."

Physical Examination and Laboratory Studies. General examination reveals hypertensive cardiovascular disease with a blood pressure of 182/132 mm. Hg. Laboratory studies and neurological examination are nor-

mal. Past medical history includes hysterectomy in 1942, ventral hernia repair in 1958, and cholecystectomy in 1959.

LIFE SITUATION

One of nine children, the patient was born and reared on an Iowa farm, part of a large family bereft of affection. "All we knew was hard work," she said. She quit school after the eighth grade to help out at home. At the age of twenty-two she was removed from this rather drab existence when she married a farmer whom she calls, "the best man in the world." Her husband, now a bent "crotchety" old man who also related more to the land and to the farm than to his wife, has changed from the ruddy-cheeked, pleasant-talking youth who had brightly courted her. Yet her mind's eye remains the same and, in a trick of nature, thinks that she is still young and deserves all his old attentions.

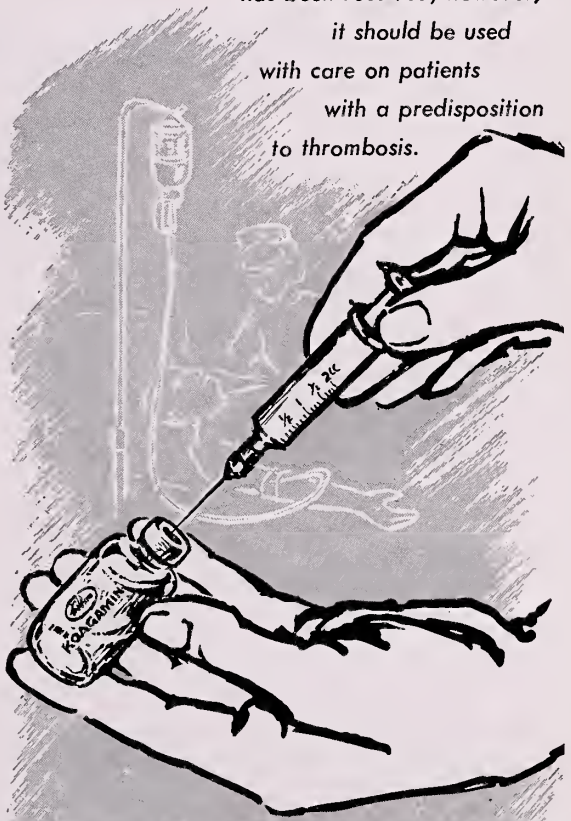
They have one daughter, now married and living on the home farm. The patient invested all her love in their daughter and now this sunny child has matured, married and settled. This loss she could never understand, couldn't fathom, and is revealed in her inward thoughts; "Heaven to me is when my daughter was young, when she needed me and smiled at me when we used to spend happy mornings baking for our family in our old home on the farm."

Case 4.

A good-looking, well-preserved widow of forty-nine was admitted in April, 1962, for treatment of depression. Onset is related to the death of her husband five months previously after two and one half years of rapidly developing multiple sclerosis. During this period he was an invalid in his home and since he required constant care, his wife could not get away during his illness. She said, "I knew caring for my husband just drained me; I had little life left when he died." Occasionally she would tell him off and then

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feel better. Furthermore, her beloved father died in 1960. She felt this loss deeply and said, "First I lost my father, then also my husband, the two people in the world who loved me."

She became severely depressed about one month after her husband's demise, characterized by loss of interest and energy, withdrawal, insomnia, and suicidal trends, and by digestive symptoms of anorexia, inability to digest food, and a constant feeling of fullness in her stomach. She has lost thirty pounds since the onset of the depression. In the past six months she has been to five or six doctors and gets angry because she can't get relief. Although her history is quite typical, she was not treated for depression before her hospitalization. In this interval she has slipped from mourning to introjective, suicidal depression. In recent months she has been staying with various relatives, refusing to stay alone in her own home.

Physical Examination and Laboratory Studies. Physically and neurologically she is normal. Fourteen years ago she had an appendectomy and made an excellent recovery. She has given birth to two babies, both stillborn.

LIFE SITUATION

The patient was the eighth born of six boys and four girls. Her father was quick-tempered but she was definitely his favorite. She always wished to be the center of attention and the rest of the family sort of stepped aside for her to avoid friction. Her mother, however, quietly ran things in the family. The patient was graduated from high school and married when she was twenty-one. This was an essentially good marriage, but she was the boss. She always tries to run everything and everyone, and tends to "take over" in any situation. Her husband, like her father, was extremely kind to his "spunky" wife. With her compulsive and narcissistic behavior she was able to put on an extremely good "front," but was in reality very dependent on her husband who was the epitome of kindness and "salt of the earth" type. Her suicidal depression with resultant psychosomatic gastro-intestinal symptoms was definitely related to the loss of her husband and probably to feelings of guilt over the way she had treated him.

SUMMARY

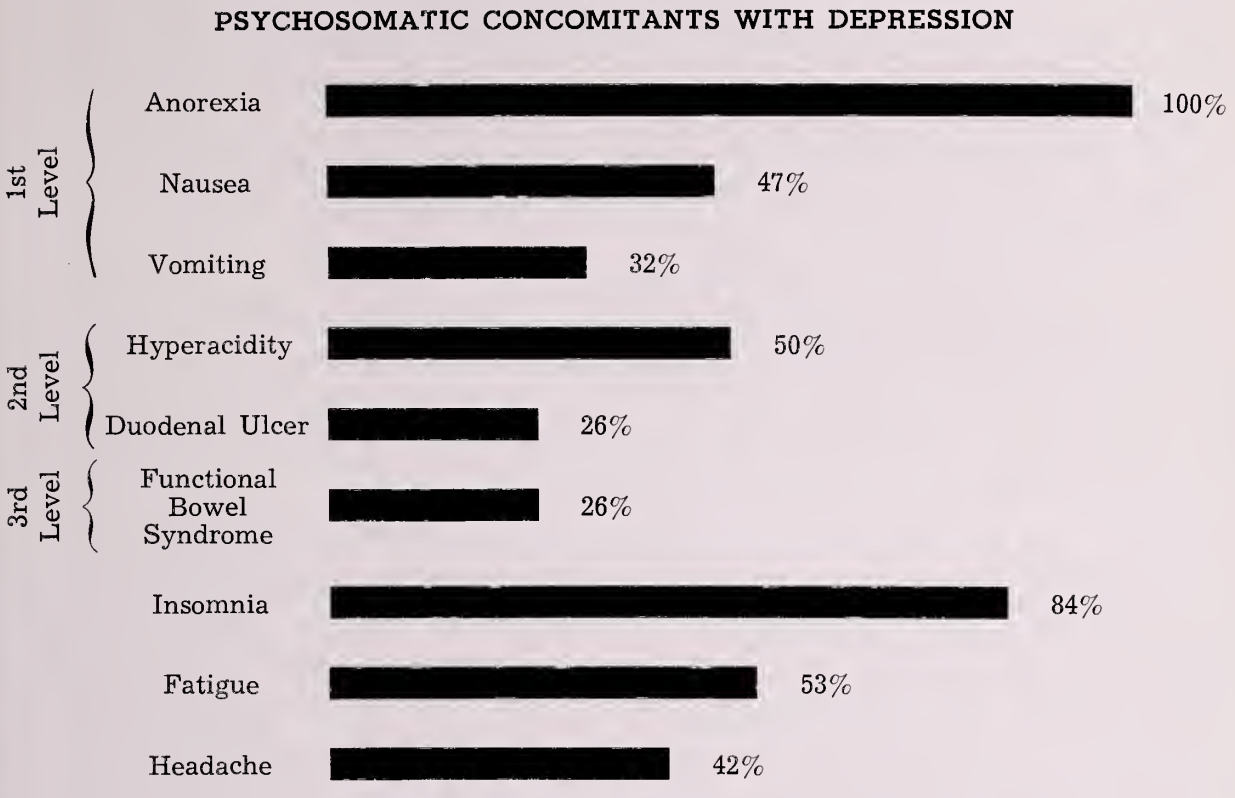
Gastro-intestinal complaints, then, may be foremost and may mask a common clinical entity, endogenous depressions. The dangers of such a misdiagnosis have been brought out. Precipitating cause of the depression generally involves the loss of self-esteem. Loss of work energy as with the second patient whose age began creeping up on him, and loss, separation or death of a loved one, as the third patient whose daughter grew away from her, or the fourth patient who lost her husband are examples. Faulty interpersonal relationships with loved ones, as exemplified by the first patient with an alcoholic husband, and injury to the concept of masculine or feminine role through bodily injury, illness, or surgery as seen in the second patient with his post-operative exacerbation are still other examples of loss of self-esteem.

The precipitating event is perceived as a loss by the patient, and his background and longitudinal development often explain his behavior. Intrapersonal defenses are marked by repression and compulsions. Part of the intrapersonal difficulty is manifested by psychosomatic symptomatology. Interpersonal relationships are characterized by suppression and conformation.

Therefore, these conforming people introject their feelings, resulting in guilt, depression and often an unconscious desire to be punished. Psychosomatically, it is as if they had swallowed their cares with resulting "bellyaches."

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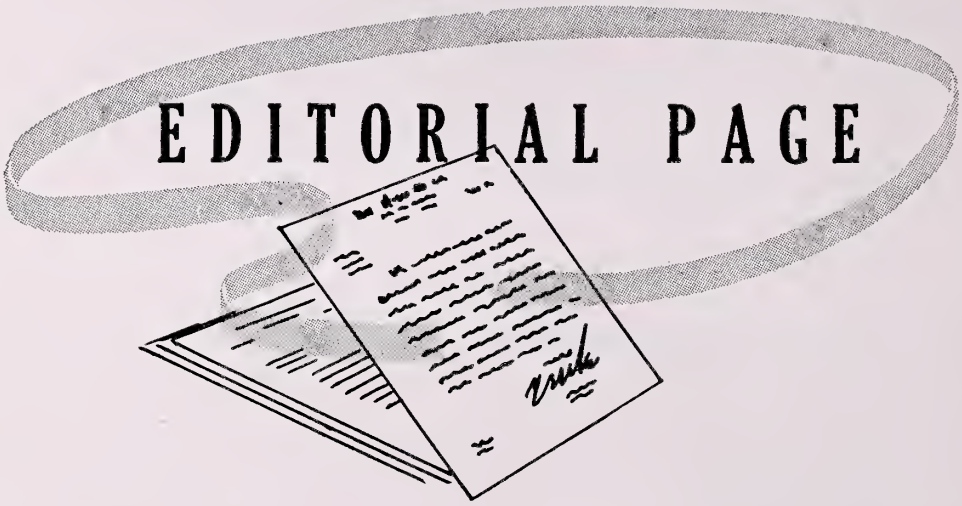
Signed: R. E. Van Demark, M.D.

A NOTE OF SYMPATHY

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THE PRESENT STATUS OF FLUOTHANE (HALOTHANE) ANESTHESIA

The recent withdrawal of federal approval of Fluothane has placed its use in a controversial status. Since its introduction in 1956, it has been satisfactorily employed in millions of anesthetic experiences in England, United States and other English speaking countries. Nevertheless, under present conditions the medicolegal implications of its use require proper selection of cases and due care in its use.

Recently there have been reports of two fatal cases of hepatic necrosis following Fluothane anesthesia and another report of 8 non-fatal cases with liver disturbance following Fluothane anesthesia. In these 8 cases, the usual pattern was fever together with headache, anorexia, malaise and lethargy and fatigue. Most of the cases had jaundice and liver enlargement and elevation of the SGOT and SGPT with varying evidence of biliary obstruction. Abnormalities of total and differential white cell count were common. Skin rashes occurred in some patients. In nearly all cases liver disturbance followed consecutive exposures to Fluothane anesthesia.

In view of the fact that most cases have occurred after repeated administration of the drugs, there is a feeling that the liver effect is the result of hypersensitivity due to drug. Other factors favoring this hypersensitivity are the prolonged incubation period and the eosinophilia often noted in the peripheral blood.

The drug must be looked upon with suspicion even though the risk is small. Its risk has not been fully assessed. For the present it would seem advisable to avoid the repeated use of the anesthetic on the same individual as well as those individuals with known or suspected liver or biliary tract disease. Halothane is not recommended for obstetrical anesthesia. It may increase cerebrospinal fluid pressure in places with markedly raised intracranial pressure. It must be carefully administered. The patient must be watched closely for signs of over-dosage; sudden exposure to relatively high concentrations can lead to profound hypotension with cardiac arrest.

Robert E. Van Demark, M.D.

M.A.A. IMPLEMENTATION DRAGS IN SOUTH DAKOTA

Implementation of the Kerr-Mills Law on Medical Aid to the Aged was slowed considerably by inaction on the part of the Department of Health, Education and Welfare during the summer months.

The bill, which passed the legislature and was signed into law early in March, was to become effective on July 1st. The State Department of Welfare, under direction of the State Welfare Commission, set up a proposed

plan and under the proposals negotiated with Blue Cross and Blue Shield to underwrite the program. Three Hundred Nine (309) insurance companies who were asked to bid on the underwriting of the program elected not to submit bids.

The proposed plan and copies of the agreement between the State Welfare Department and Blue Cross-Blue Shield were submitted on June 10th to the Health, Education and Welfare Office in Kansas City for approval. According to Welfare Department sources, the Kansas City office submitted this information to Washington, D. C. on June 17th, although H.E.W. officials in Washington indicate that they had not seen the plan on June 30th.

It was not until August 22nd that the material was returned to the Welfare Department in South Dakota requesting additional information and some opinions of the state's attorney general. The Welfare Department referred those matters to the attorney general, and also referred questions to the executive directors of Blue Cross and Blue Shield.

On September 26th, the Attorney General's office announced its decision, which appeared to give a green light to the approval by federal authorities.

As of the time of this writing, the inauguration date of the program has not been set, and it begins to look as if the earliest date of start will be the first of the year.

INVITATION TO HEAR DR. ANNIS

Dr. Edward R. Annis, President of the American Medical Association, will be the guest speaker at the annual Chamber of Commerce banquet in Watertown, South Dakota. The event will be held December 9, 1963 at 7:00 p.m. at the Civic Arena. The tickets are $4.00, and advance reservations should be made. Anyone interested should contact G. R. Bartron, M.D., Bartron Clinic, Watertown, South Dakota.

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

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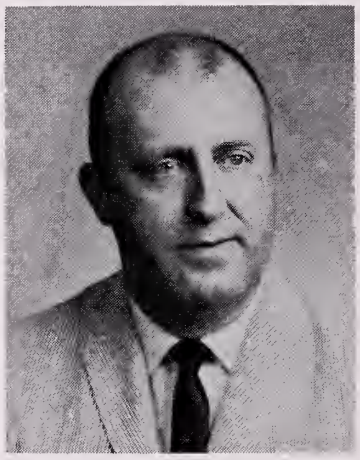
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PRESIDENT'S PAGE



Dear Fellow Members:

I am sure that each member of the South Dakota State Medical Association is wondering what happened to the M.A.A. program (Medical Aid to Aged). As each of you knew, the South Dakota Legislature, in 1963, authorized a pilot study with the hope of making an accurate head count of those people who could qualify. As you will recall, the Welfare Commission's estimates seemed to be much higher than we as individual practicing physicians felt they would be. Indeed, some of the insurance authorities concurred in the same, and it was felt that perhaps the Welfare Commission was making a bigger production of the needs of many of our older people than was really the case.

After the Legislature authorized the pilot program there was a great deal of red tape and detail to be untangled since the pilot program actually authorized the plan to be truly an insurance one — namely Blue Cross and Blue Shield. Those of us who have followed this carefully, cannot help but feel that there were some undue delays which seemed almost intentional. To put the blame on our own State Welfare Commission would seem unfair, and yet, somewhere between our State Commission office and the office in Washington the solution to this problem of aging has been "administratively lost." It is perhaps with some degree of justifiable bitterness that Doctors say, "Well, that is the way that everything in government medicine would run." I am sure that the people on our Welfare Commission would understand how we Doctors become perturbed when such a thing happens, because I am certain they realize that in our chosen work such similar delays in the practice of medicine could cost patient lives.

Now after such a long-winded recapitulation, each of you might ask what can each of us do about it? I feel the time has come for each of us to appraise our older people of as much detail as possible. A letter writing campaign by our Senior Citizens to Mr. Celebrezze of Health, Education and Welfare might be in order, and I would suggest that you recommend it to your older patients. The Association will try to keep each of you posted as to the progress of this bill, but it seemed fitting that some time be taken to discuss it with you, Doctor to Doctor, through the Editorial page of our Journal.

Fraternally,
Robert H. Hayes, M.D.

MINUTES OF THE COMMITTEE ON LEGISLATION MEETING

Saturday, September 28, 1963
Medical School, Vermillion, S. D.

The meeting was called to order at 4:10 p.m. by **Dr. Quinn,** chairman of the committee. Present at the meeting were **Drs. R. H. Quinn** and **R. F. Hubner,** members of the Committee, and **T. H. Willcockson, M.D.** Also present were staff members John C. Foster, Richard C. Erickson, and Patty Butler.

Mr. Foster explained briefly the present status of the M.A.A. program under Kerr-Mills in South Dakota. Dr. Quinn moved that the Committee go on record as approving further efforts by physicians in the State to defeat legislation to provide medical care for the aged through Social Security. The motion was seconded by Hubner and carried.

The Committee then considered the proposal submitted by the Bar Association regarding physicians' confidential relations privilege. The Committee recommends to the Council that the State Medical Association endorse the proposal of the Bar Association. (Recommendation passed by a 2 to 1 vote).

The Committee discussed the sterilization law of North Carolina. Dr. Quinn moved that the matter be tabled at the present time. The motion was seconded by Dr. Hubner and carried.

The Committee considered the recommendation of the Workmen's Compensation Committee that legislation be introduced at the next session of the Legislature providing for appointment of the Industrial Commissioner for a six-year term by the Governor. Dr. Hubner moved that the Committee recommend to the Council that steps be taken by the Association's legal advisers to determine the activities necessary to accomplish this change and that the Association endorse the proposal to increase the continuity in the office of the Industrial Commissioner. The motion was seconded by Dr. Quinn and carried.

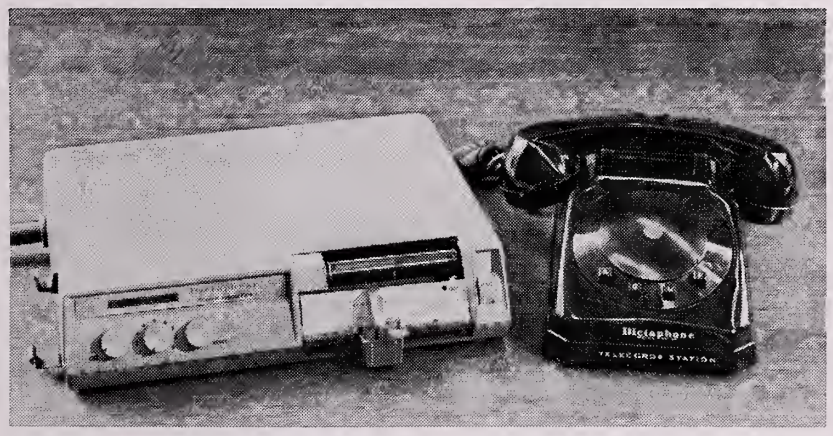
The Committee considered the proposed law to set up a graduated system of charges for the care of the mentally ill at Yankton State Hospital. Dr. Quinn moved that the Committee recommend to the Council that endorsement be given to this proposed law. The motion was seconded by Dr. Hubner and carried.

The Committee considered the recommendation of the Yankton District Medical Society that changes be made in the law regarding the appointment of the members of the Board of Medical Examiners. The recommendation is that the law be changed to provide for the election of the members of the Board by the State Medical Association; also that the law be changed to give the members of the Board immunity from civil suits. Dr. Hubner moved that copies of the Washington State law be forwarded to each District Secretary for discussion and consideration by the Districts and that it be brought to their attention that only the above two changes are recommended and not the formation of a new Board for disciplinary purposes. The motion was seconded by Dr. Quinn and carried. It was also suggested that letters be written to each member of the Board of Medical Examiners to get their reaction to the proposed changes, with an explanation of the intent of the Yankton District in proposing them.

Mr. Foster discussed the $2.00 annual registration of the Board of Medical Examiners and the financial condition of the Board. Dr. Quinn moved that the Committee recommend to the Council that the State Medical Association endorse a $5.00 annual registration fee for all licentiates of the South

(Continued on Page 44)

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SAMA REPORTS TO SDSMA

(Ed. note: The following is a letter report on the Student AMA meeting in Chicago. Note the actions taken by the students which may be contrary to previous thoughts of the profession.)

In behalf of myself, Steve Curtis, the President Elect of the Student American Medical Association, South Dakota Chapter, and the chapter members, I would like to thank you for the one hundred dollar contribution you presented to us for expenses to send a delegate and alternate delegate to the National SAMA Convention. This convention was held in Chicago May 1 through 5 and it proved to be one of the most stimulating and enlightening conventions of SAMA's short history.

I was privileged to serve as a member of the Legislative Committee which studied and revised most of the resolutions submitted by the House of Delegates. I also am pleased to inform you of the election of Robert O. Voy as National SAMA President. Bob is a South Dakota Medical School graduate and my predecessor as chapter president.

The following is a brief outline of the activities and resolutions passed by the House of Delegates during the convention.
Resolution #1A

Subject: Federal Loans to Medical Students Through HR-12.

WHEREAS: There is a need for additional aid to medical students as demonstrated by the AAMC report of 1959, the Bane Report of 1959, local Student American Medical Association surveys and government sources, and

WHEREAS: The AMA-ERF Loan Fund is a great service to medical education, but because of the 5½% interim interest rate beginning at the initiation of the loan and the 6½% payout interest accumulating until repayment is complete, because of the requirement that repayment begin the fifth month after completion of full-time training and, because the maximum yearly loan is $1,500 available over a seven year period, the AMA-ERF Loan Fund is more practical for the intern or resident who can begin repayment before the interest rates mount, and

WHEREAS: HR-12 proposes a loan fund which will bear interest on the unpaid balance of the loan, at the rate of 3% per annum, computed only for periods during which the loan is repayable, the loan becoming repayable three years after completion of full-time medical training, the maximum yearly loan being $2,000 available over a four-year period (a more realistic figure for medical students), and HR-12 has provisions for suspension for up to three years of active military service or peace corps, and

WHEREAS: Nearly 10% of all medical students in the United States have been granted AMA-ERF loans with a relatively high rate of interest, and

WHEREAS: With more specialization in medicine, medical education is taking longer for completion, and

WHEREAS: 68% of the thirty-one SAMA Chapters responding to the poll taken by the Standing Committee on Medical Education in 1961-62 were in favor of federal loans, and

WHEREAS: Potential medical school applicants are being attracted into other scientific fields because of greater availability of loans and grants,

BE IT RESOLVED, That the House of Delegates of SAMA go on record as being in favor of federal loans to medical students as proposed in HR-12, as a supplement to presently existing programs, and

BE IT FURTHER RESOLVED, That SAMA make its opinion on this bill known to the Appropriate Committees of the United States Congress.

The passage of this resolution was a reversal of the stand taken in 1962 by the SAMA House of Delegates.

Resolutions Nos. 10 and 23. After careful deliberation, your Committee recommends substitute resolution #10A, as combining the intent and content of Resolutions 10 and 23.

WHEREAS: A knowledge and understanding of both normal and disease processes is greatly advanced by animal experimentation, and

WHEREAS: The use of animal experimentation is a necessary adjunct to the development and perfection of new and better therapeutic methods and agents, and

WHEREAS: The experimental use of such animals is best determined by qualified individuals, and

WHEREAS: The investigators should not be encumbered with unnecessary licensure, limitations, and inspection of the methods and facilities employed, and

WHEREAS: Several bills have been introduced to the Congress of the United States which would severely impede use of vertebrate animal investigations used in the advancement of medical and physical sciences, therefore,

BE IT RESOLVED: That the Student American Medical Association go on record as opposing all legislation which might impede the use of vertebrate animals and the manner of use of vertebrate animals for the advancement of medical and physical sciences, and,

BE IT FURTHER RESOLVED, That each member of each Chapter personally inform the United States Senators and Representatives of his home state regarding his opposition to all such bills.

Resolution #4A.

Subject: Federal Income Tax

WHEREAS: The long course of medical education today is financially burdensome for most students and nearly prohibitive for others, and

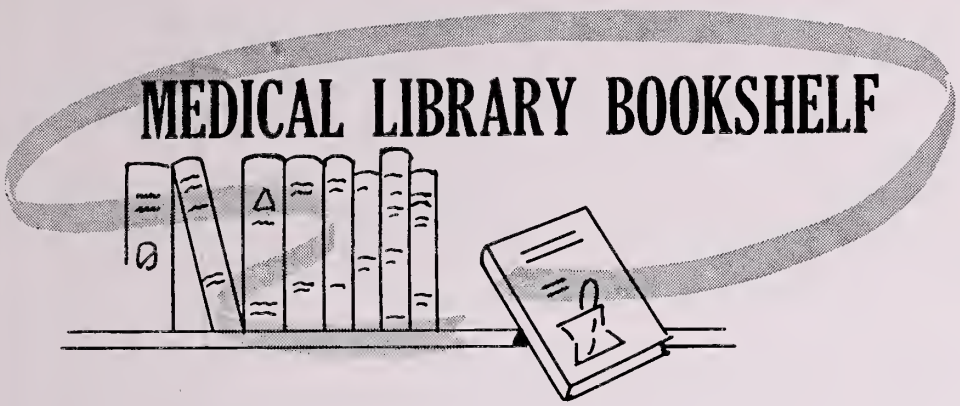
WHEREAS: This financial hurdle has become a major factor in deterring many qualified undergraduates from pursuing a medical career, and

WHEREAS: There is a growing need for a greater number of new physicians in the United States, and

WHEREAS: The U. S. Treasury Department Internal Revenue Service does not allow income tax deductions for medical school expenses and, thereby unfairly penalizes the medical students who, or whose spouses and/or parents earn wages to help defray such expenses, while at the same time does NOT consider as reportable income such financial aid as scholarships, most student fellowships, and exchanges of room and/or board for student services, and

WHEREAS: The Internal Revenue Service does allow income tax deductions for educational expenses, providing such education is "for the purpose of: (a) Maintaining or improving skills required in (one's) employment or other trade or business, or (b) Meeting the express re-

(Continued on Page 44)



The fourth annual regional meeting of the American College of Physicians of South Dakota was held in the School of Medical Sciences on Saturday, September 28, 1963.

The morning session was presided over by Dr. Donald Kegaries, Governor of the South Dakota American College of Physicians, and the afternoon session by Dr. John Calene, former Governor.

Three medical staff members from the University of Iowa Medical School were guest speakers: Dr. William E. Conner, Associate Professor of Internal Medicine who talked about Coronary Atherosclerosis; Recent Advances in the Study of Cause and Treatment: Dr. John W. Eckstein from the Cardiovascular Research Laboratory who discussed Congestive Heart Failure; Basic Causative Mechanisms, Recent Advances in Therapy: Dr. Walter K. Kirkendall, Professor of Medicine and Director of the Cardiovascular Research Laboratory whose talk was on Hypertension; Recent Advances in the Causes and Treatment.

All three were members of a panel discussion on Outpatient Evaluation of the Extent of Cardiac Disease in a Patient, with Dr. Theodore Sattler of the Yankton Clinic and Professor of Medicine at this University as the moderator.

During this panel discussion Dr. Kirkendall stated that he used the New York Heart Association **Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels,** a new edition of which has just been published. This may be purchased from the New York Heart Association Inc., 270 Park Avenue Building, New York 17, N. Y., for about $5.00.

A good outline of the diagnostic criteria of heart disease, published by the New York Heart Association is found in **Physician's Handbook,** 12th ed., Los Altos, California, Lange Medical Publications, 1962, p. 42. This includes examination of the heart, peripheral vessels and lungs. There are illustrations of x-ray silhouettes of the heart, giving an approximate idea of the "normal" cardiac silhouette and a chart showing the theoretical transverse diameters of heart silhouette for various heights and weights.

Standard method of blood pressure determination has been outlined from an article by the American Heart Association Committee to revise standardization of high blood pressure readings with Dr. Carl J. Wiggins as chairman. This article entitled "Recommendations for Human Blood Pressure Determinations by Sphygmomanometers" is found in **Circulation** 4:503, 1951.

The table on p. 50 of the **Physician's Handbook** incorporates concepts of range of normal blood pressure and is taken from an article by Dr. Arthur M. Masters and others, "The Normal Blood Pressure Range and Its Clinical Implications" **Journal of the American Medical Association** v. 143, 1950, p. 1464. This table gives the normal range, mean, and

hypertension lower limit for men and women, based on sex and age, and for systolic and diastolic. In this article a warning is given that dependence for diagnosis on a single observation or test may be a dangerous practice, and the evaluation of the blood pressure reading without correlation with the entire examination of the patient is unsound.

The **Physician's Handbook** continues with the Keith-Wagner Classification of Hypertensive Retinopathy; Special Circulatory Tests; Circulation Time Determination; Cardiac Catheterization; Angiocardiography, and Examination of Peripheral Vessels. There is also a chapter on Electrocardiography with illustrations of normal Ecg. patterns and an explanation of techniques for reading the electrocardiogram and Ecg. interpretation.

At the afternoon session the out of state speaker was Dr. Charles P. Kolars, Assistant Director, Cardiac Work Evaluation Center and Clinical Instructor of Medicine at the University of Minnesota, who talked about Rehabilitation and Return to Work After a Myocardial Infarction. The panel discussion afterwards in which all of the guest speakers participated was on Return of the Cardiac to Useful Employment.

Esther Howard
Medical Librarian

PNH—

(Continued from Page 29)

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_____ (1958). The mechanism of action of preparations of thrombin on hemolysis of PNH—red cells. **Jour. Lab. & Clin. Med.** 52:282.

KABAT, E. A. (1956). Heterogenicity in extent of the combining regions of human anti-dextrans. **Jour. Immunolog.** 77:377.

MUNN, J. I., and CROSBY, W. H. (1957). PNH—evidence of defect of red cell stroma manifested by abnormalities of lipids. **Proc. Soc. Exper. Biol. & Med.** 96:480.

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TREFFERS, H. P. (1958). Serology and immunochemistry. Pp. 114-148. Bacterial and Myocotic Infections of Man, R. J. Dubos, editor. 3rd Edition, J. B. Lippincott Co.

WAGLEY, P. F. and RUMSFELD, J. A. (1958). A clinical note on Marchiafava-Micheli disease. **AMA Arch. Int. Med.** 101:300.

WINTROBE, M. M. (1961). Clinical Hematology. 5th Edition. Lea and Febiger, Philadelphia. Pp. 640-645.

MINUTES—

(Continued from Page 41)

Dakota Board. The motion was seconded by Dr. Hubner and carried.

The matter of Federal legislation in the field of mental illness was discussed.

The Committee recommended that the Council pass a resolution asking the AMA to clarify their position on federal grants. The resolution would then be introduced at the Portland AMA Interim Session.

RESOLUTION PRESENTED BY THE COMMITTEE ON LEGISLATION AND ADOPTED BY THE COUNCIL OF THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

WHEREAS, The American Medical Association has taken specific stands on many legislative issues involving the use of Federal Funds to finance medical services, staffing and construction; and

WHEREAS, These stands have not always been consistent in support or in opposition to the provision and use of such Federal Funds; therefore,

BE IT RESOLVED, That the South Dakota State Medical Association requests the American Medical Association to review its entire policy regarding the use of Federal Funds for medical services, staffing and construction, bearing in mind the inadvisability in general of the use of such Federal Funds, and to issue a report on this matter at the 1964 Clinical Session; and further,

BE IT RESOLVED, That a copy of this resolution be distributed to the component member associations of the American Medical Association.

The Committee discussed legislation on the "child beating syndrome." Mr. Foster was requested to obtain a copy of the model law written by the Department of HEW. The Committee will consider the legislation at a future meeting and will report to the Council at the January meeting on their recommendation.

The meeting adjourned at 5:15 p.m.

SAMA REPORTS—

(Continued from Page 42)

quirements of (one's) employer, or the requirements of applicable law or regulations, imposed as a condition to the retention of (one's) salary, status or employment;" Therefore,

BE IT RESOLVED THAT: SAMA go on record in favor of federal income tax revisions necessary to allow the deduction from income earned by an undergraduate or graduate student and/or his/her spouse, and/or parents, such educational expenses as tuition, fees, necessary books, and equipment, and

BE IT FURTHER RESOLVED THAT: The 1963 House of Delegates urge the SAMA membership to write to their individual congressmen, urging that such federal income tax revisions be made in the near future.

BE IT FURTHER RESOLVED THAT: SAMA institute a program of communication with the appropriate Federal Bureau with the express purpose of obtaining said tax exemptions.

Outstanding among the guest speakers were: Michael E. DeBakey, M.D.; Corbett H. Thigpen, M.D.; Walter C. Alvarez, M.D.; Albert C. Ritt, M.D.; George M. Fister, M.D.; George C. Stilwell, M.D.; and others.

Again, thank you for your interest in our student organization. Perhaps in the near future some of us can join the ranks in your fine South Dakota Medical Association.

Sincerely yours,
Merle R. Pounds, President
South Dakota Chapter
S.A.M.A.

This is your MEDICAL ASSOCIATION

NEWS • NOTES • • • BIRTHS • • • CHANGES • NEWS

5-DAY SMOKING PLAN UNDERTAKEN

First attempts by the Seventh Day Adventists to start the highly publicized "5-Day Plan to Stop Smoking" in South Dakota were made September 28 to October 2 in Sioux Falls.

Five group therapy sessions were held at the hospitality room of the Home Federal Building.

The originator of the plan was Dr. J. Wayne McFarland, who is a specialist in physical medicine and rehabilitation.

* * *

DELL RAPIDS CLINIC REOPENS

After holding office hours in the hospital for a time, the Dell Rapids Clinic has reopened its offices downtown. The building which houses the offices was formerly the hospital. It has recently undergone considerable remodeling and redecorating, with the addition of a new reception room.

* * *

A. P. Peeke, M.D., Chairman of the Association's Committee on Rural Health, represented the Association at the National Rural Health Conference in Hot Springs, Arkansas, in mid-September.

The 28th Annual Session of the International Medical Assembly of Southwest Texas will be held in San Antonio, Texas, at the Granada Hotel, January 30 through February 1, 1964. Those interested in receiving further information may write Dr. William M. Center, President, or Mr. S. E. Cockrell, Jr., Executive Secretary, 202 West French Place, San Antonio, Texas, 78212.

* * *

N. B. Saoi, M.D., has established his practice in the specialty of urology at Yankton.

* * *

E. W. Sanderson, M.D., Sioux Falls, was elected president of the South Dakota chapter of the American College of Physicians at the annual regional meeting in Vermillion, South Dakota. Other officers include **Dr. C. J. Clark,** Watertown, president-elect; and **Dr. John W. Argabrite,** Watertown, secretary-treasurer. **Dr. Clark F. Johnson** of Yankton was elected to a three-year term on the board of trustees. Guest speaker was Edward Rosenow, Jr., executive director of the American College of Physicians.

YANKTON DISTRICT MEETS SEPT. 17TH

Eighty physicians, wives and guests of the Yankton District Medical Society met at Fort Yankton on September 17th for the regular Fall meeting. Dr. J. St. Albans, Professor of Radiology at the University of Nebraska, was the guest speaker. Dr. Robert Hayes, state association president, made his official visitation. Dr. J. Patrick Steele, district president, presided at the meeting and conducted the business session which saw the district endorse a proposal for graduated changes at Yankton State Hospital.

* * *

S.D.J.C.I.C.P. MEETS IN HURON

The South Dakota Joint Council for Improvement of Care of the Patient met in Huron, on Wednesday, September 25th. Attending the meeting were about twelve people, representing the various groups interested in patient care, including the State Hospital Association, State Department of Health, Licensed Practical Nurses Association, State Nurses Association, and the State Medical Association. Repre-

senting the State Medical Association were Drs. C. L. Vogele, Aberdeen, chairman of the committee, D. A. Buchanan, Huron; M. E. Sanders, Redfield; and J. A. Muggly, Madison. Also attending was executive secretary John C. Foster, who sits as an ex-officio member of the committee.

* * *

Dr. Walter A. Kitzler, who recently opened his offices in Faulkton, South Dakota, replacing **Dr. T. R. Marvin,** will establish a clinic at the Eagle Butte Community Hospital two days a week.

* * *

DOCTORS LICENSED IN 1962-63

The South Dakota State Board of Medical Examiners, in its annual report to the Governor, indicated that they had licensed 21 doctors by reciprocity in the period July 1, 1962 to June 30, 1963; and also had licensed 19 by examination.

Of the total of 40 physicians licensed, 19 are currently practicing in the State, while others are finishing residencies or military obligations.

* * *

The Educational Unit of the First Methodist Church in Deadwood was consecrated recently as a memorial to **Dr.** and **Mrs. F. S. Howe,** pioneer Northern Hills physician and his wife. The building was a gift of the Howe children. Dr. Howe was a past-president of the South Dakota State Medical Association.

The American Rhinologic Society will present an international postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid," May 5-15, 1964. The course will be presented at the University of Cincinnati College of Medicine and Christ Hospital, Cincinnati, Ohio. Further information may be obtained from Dr. Raymond L. Hilsinger, 2403 Aubrun Avenue, Cincinnati 19, or American Rhinologic Society, 530 Hawthorne Place, Chicago 57.

* * *

Dr. George A. Skelly, formerly at McVille, North Dakota, has located at Lemmon with **Dr. F. C. Totten.**

* * *

The Hot Springs Veterans Administration Center has a vacancy for a ward physician assigned to the Medical Service. Further, due to a mandatory age retirement of another physician next spring, another vacancy will occur in May, 1964. Salary would range from $11,150 to $12,845 per annum, depending on the physician's qualifications. Candidates must be citizens of the United States, must hold a degree of Doctor of Medicine, and must be licensed to practice in one of the fifty states. Housing will be available for a physician applying for the current vacancy. Interested physicians should contact either the Chief of Staff or the Personnel Officer at the Center for further information.

RESULTS OF ANALYSIS OF "KREBIOZEN"

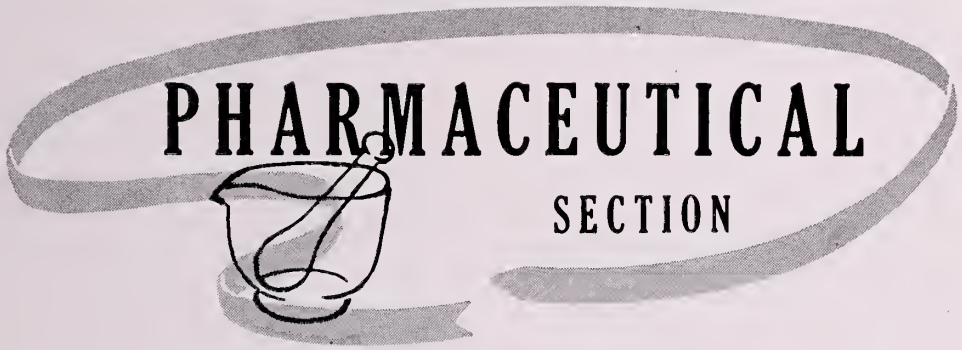
The Food and Drug Administration has identified the "Krebiozen" powder given to its inspector by Dr. Stevan Durovic and Dr. Andrew C. Ivy on July 12, 1963, as creatine. Creatine is an amino acid derivative plentifully available from meat in the ordinary diet and is a normal constituent of the human body. It is readily available as an inexpensive laboratory chemical. Creatine is in muscle tissue and in blood in lesser amounts. The human body will produce in 24 hours as much as 100,000 times the amount of creatine as the alleged content of "Krebiozen" in one ampule.

* * *

American College of Allergists Graduate Instructional Course and Twentieth Annual Congress, March 1-6, 1964, The Americana, Bal Harbour, Miami Beach, Florida. For further information write: John D. Gillaspie, M.D., Treasurer, 2141 14th Street, Boulder, Colorado.

* * *

Dr. John T. Elston, Rapid City, South Dakota, attended the National Conference on Hospital Acquired Infections in Minneapolis, Minnesota, on September 4, 5, and 6, as a representative of the South Dakota State Medical Association. The meeting was sponsored by the College of Medical Sciences and the Mayo Foundation of the University of Minnesota, the Communicable Disease Center and Division of Hospital and Medical Facilities of the Public Health Service.



GUILFORD C. GROSS, PH.D.
EDITOR
Division of Pharmacy
South Dakota State College
Brookings, South Dakota



PHARMACY IN MEXICO

by

Kenneth Redman, Ph.D.*

Before visiting Mexico, I suppose I had the common "gringo" manana concept of our neighbor below the border — swarthy people with their siestas, fiestas and Don Juans with big sombreros serenading senoritas under their balconies. A moment's reflection, however, brought me to the realization that I knew little of my own profession of pharmacy as practiced by the Latinos — their schools of pharmacy, their courses in pharmacognosy (my special field of interest), or retail pharmacy.

How then, could I expect to know the country and its people without visiting it? Any illusions about knowing these people abruptly ended within ten minutes after driving aross the border in Nuevo Laredo. I soon learned that a "desviacion" (detour) sign directs one away from the closed road only and that one is supposed to find his own way back to the main highway!

The area of Mexico is about ten times that of South Dakota, but the population is about fifty times that of our state. Since much of Mexico is desert, the population in the more habitable regions is quite dense. Mexico City, for instance, over 8,000 feet high, is the largest city in Latin America and the second largest in North America. It is growing so fast that steps are being taken to partially decentralize industry to other cities.

The Spanish conquest of the Indians in 1519 reduced them to slaves for 300 years; a century of dictatorship followed, which bound the peons for life to big "haciendas." Today Mexico is rapidly becoming modern, but there are still great contrasts between the old and the new. Most Mexicans are "mestizos" — of mixed Indian and Spanish blood, but there are still many Indians that speak native tongues; a small proportion of the people are of pure Spanish descent.

Fields of Practice

There are about twenty-four universities in Mexico that teach pharmacy. Some of them are private institutions, such as the Universidad Autonoma de Guadalajara; some are state schools, such as the Universidad de Nuevo Leon; some are church affiliated, such as Labastida Universidad and two are supported by Federal funds, such as the Universidad Nacional Autonoma de Mexico.

In some twenty of the universities that I visited, only the Universidad de Oaxaca had a "school of pharmacy." In all the others, pharmacy was under the dean or director of engineering, biology, chemistry or some other department. This situation exists because the course in pharmacy is combined with two or three other majors; chemistry and biology, commonly. Under these circumstances it is difficult to understand how the best interests

* Professor and Head of the Department of Pharmacognosy at South Dakota State College. Redman spent nine months in 1961-1962 cooperating in the Department of State's cultural and exchange program in Mexico.

of pharmacy can be served, even though some of the curricula now are five-year programs. Pharmacy graduates of Mexican universities are licensed to practice anywhere in Mexico.

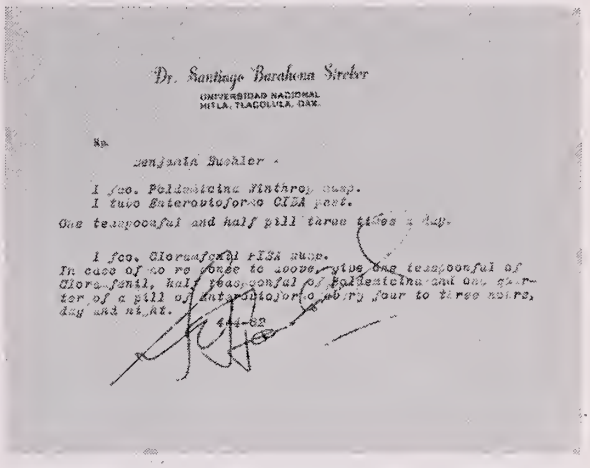
Most of the licensed pharmacists own and operate or are employed in retail stores. Many of the stores go under the name "Farmacia" but some use the title "Botica," the older name, from the days, presumably, when plant drugs predominated. Another store name sometimes used is "Drogueria," i.e., a place where drugs are sold. Prominently displayed under the store name is either "primera clase" or "segunda clase," thus designating the store as either a first-class or second-class drug store (Fig. 1). The first-class



Fig. 1.—Botica Fenix, a drug store of the "first class," owned by Sr. Miguel Torres M., Tijuana, Mexico, showing the perfume section, an important part of most Mexican drug stores.

stores generally are in the larger towns and cities and are under the supervision of a "Farmaceutico con Titulo," corresponding to our registered pharmacist. These stores often proudly display the name of the supervising pharmacist on their signs and windows. If he is a professor, so much the better, the institution with which he is affiliated being so indicated. Many pharmacy professors work part time in drug stores because the university pay is apt to be more honorary than monetary. Since all stores operate under a Federal pharmacy law and it is only required that the supervisor be in the store three hours a day, one registered pharmacist may be in charge of two or three stores. The second-class stores are generally in small towns where there is no registered pharmacist, so they are supervised by a "Pharmaceutico Practico," evidently a man with only practical experience.

Many of the retail pharmacies carry fewer sidelines unrelated to pharmacy than is common in the United States, restricting themselves mostly to prescription drugs, proprie-


Dr. Santiago Barahona Streber
UNIVERSIDAD NACIONAL
MEXICO, TLACOLULA, OAX.

Sr.
Benjamin Buehler

1 fco. Feldenkrais Pinthroy comp.
1 tubo Enterovioformo CIBA post.
One teaspoonful and half pill three times a day.

1 fco. Cloramfenicol PISA comp.
In case of no response to above, give one teaspoonful of Cloramfenil, half teaspoonful of Feldenkrais and one quarter of a pill of Enterovioformo every four to three hours, day and night.

Fig. 2.—A Mexican prescription, the original being 5½ x 8½ inches. Three different medicines are specified, with directions in English for an American patient. These are the only directions the patient has, since no prescription labels are used.

taries, perfumes and cosmetics. The writer did visit one drug store in Monterrey with a soda fountain and booths, but this city shows a considerable United States influence, being only about 150 miles from the border. One store, as far south as Guadalajara, was remodeling to put in a self-service department, so it may be only a matter of time to see considerably more United States drug store atmosphere in Mexico. In some of the larger stores, when a clerk waits on a customer, the customer is given a bill, the item(s) are passed to another person that wraps the package, and by the time one steps to the cashier and presents the bill for payment, the transaction is completed. If a prescription for a proprietary item is to be filled, it is handled in the same way. **The original prescription is returned to the customer, instead of directions being placed on a label.** The prescription is not numbered and there may be as many as three different medications with directions on one prescription for the patient to keep straight (Fig. 2.).

Price cutting of drugs is not much of a problem in Mexico because of a Mexican law establishing a "precio publico." Although the law requires a maximum retail price printed on the carton of a drug manufactured in

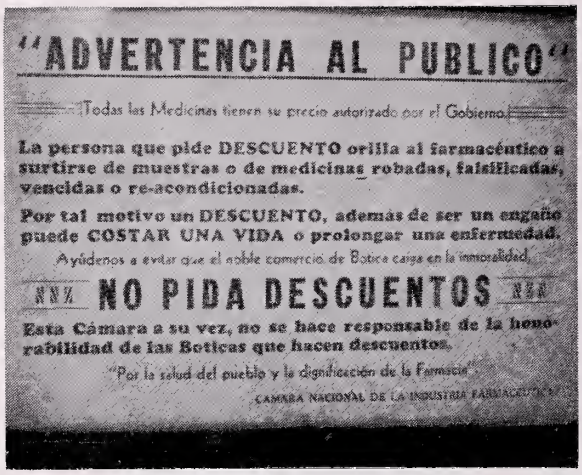


Fig. 3.—A notice to the public by the National Chamber of Pharmaceutical Industry intended to discourage price-cutting.



Fig. 4.—A kaolin tablet, "Tierra Santa" sold at the Black Christ of Esquipulas Festivals at Tlacolula, Mexico. The sick either bite off pieces and eat it or mix it with water and drink the suspension. The tablet is 2 x 2⅝ inches. The spots are red.

Mexico, it allows only a gross profit of 16.6 per cent on most items. This, of course, is already a drastic cut price. Preparations manufactured in the United States and Europe are not subjected to this price ceiling, but since Mexico has a high import duty on imported items, a more realistic profit is likely to be limited by the high retail price on such medicines. In spite of this "precio publico," however, a few stores do cut drug prices; but these prices are not advertised for individual items. Some of the stores try to make up for low drug profits in their cosmetic and perfume departments, in which the prices are not now subjected to control by the Department of Commerce. In one cut-rate store, in which all prices were supposedly cut a uniform 5 per cent, the manufacturer's suggested retail price on a printed sticker on the bottom of a carton of shampoo was deftly removed, the price raised as the purchase was made, and then the standard store discount was allowed to bring the full suggested retail price!

Evidence that the National Chamber of Pharmaceutical Industry is trying to counter the discount problem, is shown by a sign in another store (Fig. 3), which freely translated is as follows: " 'Notice to the Public,' All medicines have a price authorized by the Government. The person that asks for a discount makes the pharmacist come near to buying samples or drugs that are stolen, imitated, out-dated or reconditioned. Therefore don't ask for a discount, for besides being a fake it could cost a life or prolong an illness. Help us to avoid the noble commerce of drugs from falling into immorality. Do not ask for discounts. At the same time, this chamber isn't responsible for the quality of discount drugs. 'For the health of the people and the dignity of pharmacy.' "

Discount houses and supermarkets are rapidly being established in the larger towns and cities, and, as in the United States, are seeking a share of the toilet goods and cosmetic markets at cut prices.

Another form of retailing embraces crude drugs, many of which are collected in Mexico. Barks, herbs, roots, seeds, etc., are sold in farmer's and Indian markets. The writer recognized sarsaparilla, cocoa beans, some of the mints and others. There was a root with the suggestion of a form of a man, or deity in a Saturday morning Indian market in Oaxaca, but the writer was refused permission to take a picture of this and other crude drugs for sale in this market. One form of a kaolin tablet, Tierra Santa, sold at Tlacolula, represents the Black Christ of Esquipulas, which assumes a religious as well as a therapeutic significance (Fig. 4). These drugs are sold to the poor people, many of whom may never see a physician.

Mexico has considerably more Federal socialism than the United States. As might be expected, there are social security pharmacies in some of the larger cities.

Homeopathic pharmacy is practiced quite extensively in Mexico. Two lines of homeo-

pathic remedies were noted; those of the Leipzig Laboratories in Mexico City and the Humphreys Medicine Co. of New York. Although these stores have the name of homeopathic pharmacy, the stores observed, at least, were under the direction of a homeopathic physician and were "operated without the title of a pharmacy." These stores have signs or window displays listing the common maladies of man and the number of the homeopathic remedy to be used against it (Fig. 5). For impotency (sexual debility), for instance, the Leipzig preparation is number 70, "Tabelas Alban" (White Tablets), consisting of Agnus Cast 1 X, Phosphoric Acid 3 X, and Daminana 3 X. Five tablets every two hours is recommended! The price is 6.8 pesos (81.6c), a small price, indeed, for such a remedy!

Veterinary pharmacy is quite comparable to that in the United States. Various seed and feed stores carry veterinary medicines for sale. Even a wholesale vanilla buyer carried veterinary remedies — an important sideline during two years of near crop failure. Veterinarians, of course, retailed remedies to the public, even using the term "Veterinary Pharmacy" for their establishments (Fig. 6). It was not determined that these were licensed pharmacies. Quite a number of European veterinary products are marketed, especially those from Germany.



Fig. 5.—A homeopathic pharmacy operated by a homeopathic physician and "without the name pharmacy." The signs list common ailments and the number of the homeopathic remedy to be used against each.



Fig. 6.—A veterinary pharmacy owned and operated by a veterinarian.

Manufacturing Pharmacy

To encourage Mexican industry, Mexico has a "protective tariff" that is as high as 100 per cent, at least on some manufactured items. Also, to keep foreign capital from dominating Mexican business, there is another Federal law that requires foreign companies doing business there to be at least 51 per cent owned by Mexican citizens. The result is that many United States drug companies, such as Parke, Davis & Co., have subsidiaries, i.e., Parke, Davis y Compania de Mexico, S.A., that manufacture their line in Mexico. Others, however, such as Eli Lilly & Co., import their line into Mexico. Either way, one sees many familiar United States labels and packages, the difference being that the printing is in Spanish. Most of the United States subsidiaries are located in Mexico City. There is a relatively small amount of pharmaceutical manufacturing done by a few drug stores. The University in Mexico City was establishing a pharmaceutical manufacturing laboratory in 1962, with equipment made in Germany. The writer did not learn if the students trained in this laboratory will go into hospital pharmacy, but presumably at least some of them will.

Pharmaceutical Organization

Although there has been some form of organized pharmacy since Mexican independence in 1821, the turbulent changes in the form of government have had a marked influence on the profession. The present "Society of Pharmacy" was reorganized in 1916 as the Union Nacional de Pharmaceuticos Cientifico-Cooperativa. There is a journal of pharmacy, La Farmacia, and a legal phar-

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Fig. 7.—A small community pharmacy owned and operated by a physician that had practiced for more than 50 years. The sign indicates that the store is "always open." The metal roll front, common in Mexico, was closed more than it was open in this store.

macopoea, the Farmacopoea Nacional. In addition there is the "National Chamber of Pharmaceutical Industry," previously mentioned, which is trying to combat the price-cutting evil.

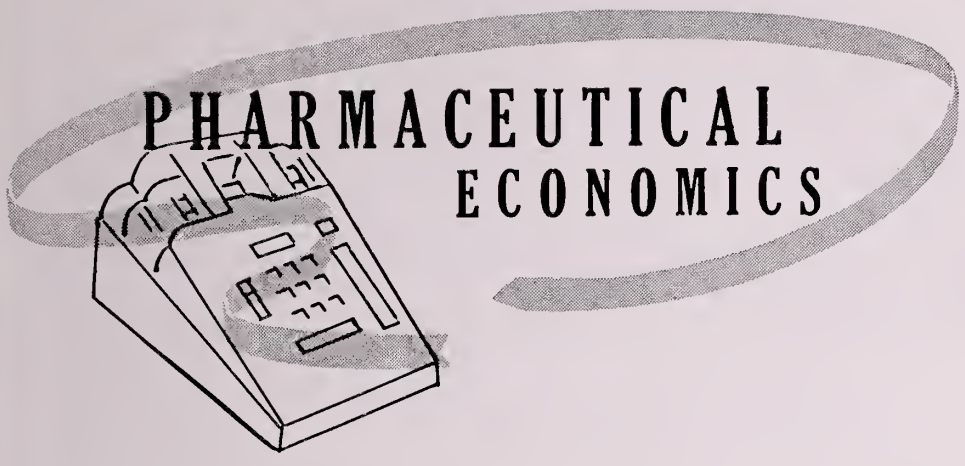
Pharmacy in Mexico resembles that in the United States in many ways. The percentage of women pharmacists is higher than in the United States, however. There are only a few drug stores with soda fountains or with self-service features. Retail drug prices are controlled by the Federal government. There are few, if any, state or local pharmaceutical associations. Pharmaceutical education is improving, which will have a beneficial effect on the profession.

Mexico is the most rapidly advancing country in the Americas, with promise of a great future.

Appreciation is expressed to Sr. Miguel Torres M., Tijuana, Mexico, for supplying information on Mexican pharmacy and a photograph of his store.

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SALES — RESEARCH AND DEVELOPMENT ACTIVITY, 1962 PRESCRIPTION PHARMACEUTICAL INDUSTRY

The following report summarizes the results of a prescription drug industry survey conducted earlier this year. Unless indicated to the contrary, data were extrapolated to represent the entire industry.

Highlights

Total annual drug industry sales rose to $3.2 billion in 1962, 8 percent more than in 1961. This included $756 million in foreign sales. Taxes paid by the prescription drug industry reached a record $387 million in 1962, about 70 percent of which was paid in U. S. federal income taxes. Capital investment per U. S. drug firm production worker is approximately $43,000.

Research and development expenditures by the prescription drug industry increased to a record $251 million, 7.8 percent of global sales. Ninety-five percent of the total was spent in the search for medicines for human use; the remainder was allocated for study of veterinary medicines. Foreign research conducted or sponsored by the industry rose to an all-time high of $13 million.

Prescription drug industry research and development spending has increased an average of 15 percent annually for the past 10 years. However, the increase in 1962 amounted to under 6 percent, less than half that of the previous year. As well, this was about half the increase anticipated a year ago when a similar survey was made by P.M.A. of member firms. For 1963, an increase of 8 percent in such expenditures is budgeted, as compared with actual expenditures in 1962.

The number of scientists employed by the industry increased 1.4 percent to 13,654 in 1962, from 13,464 in 1961. Reported net capital investment in research and development facilities and equipment rose to more than $156 million.

Prescription drug research is financed almost entirely by the industry. Added to the 1962 industry expenditures of $251 million was $7.6 million in research financed by government grants. This amounted to less than 3 percent of the total, as contrasted with an all-industry average of 58 percent government-financed research and development (National Science Foundation latest data, 1960).

The industry utilized nearly nine million animals in its testing programs, nearly 90 percent of these being mice and rats. Research activities in 1962 involved pharmacological testing of more than 168,000 chemicals and substances. Nearly 1,300 of these were tested in humans, the largest number of substances falling in these categories: hormones, antibiotics and anti-infectives, central nervous system agents and psychopharmacologic drugs, cardiovascular and hematological agents, analgesics and anesthetics.

PHARMACEUTICAL EDITORIAL

CHILDREN OFTEN ARE VICTIMS OF ALLERGIES WHICH MAY PROVE FATAL

About one-fifth of all children under 14 years of age suffer from one or more of the "major allergies," according to recent medical statistics.

Also, in more than one-half of adults now suffering from allergies, the first symptoms of these conditions started before the age of 15.

Infantile eczema (which occurs in infants most frequently during the development of their "first" teeth), hay fever, and asthma are considered to be among the "major allergies."

The current issue of Therapeutic Notes, a medical journal published by Parke, Davis & Company, states, "asthma, as a killer of children, ranks higher than certain other important illnesses.

"In 1961, asthma was fatal to 130 children from one to 14 years of age, whereas in the same year, acute poliomyelitis claimed 30 lives.

"Allergic rhinitis, although not fatal, predisposes a child to respiratory infections throughout childhood, and a peculiar facies and dental malocclusion from chronic mouth breathing eventually develop."

"Hearing also may be impaired, and frequently allergic conjunctivitis and asthma may appear."

Also children with infantile eczema often suffer the embarrassment of chronic skin eruptions throughout their entire lives.

What Causes Allergies?

The medical journal points out that probably the most important cause of allergic conditions is "an inherited susceptibility to allergic sensitization."

However, doctors emphasize that sensitivities to specific allergens are not inherited. Only a predisposition to become sensitive to various allergens, such as foods and inhalants, may be inherited.

Allergens, which are numerous and diverse, include such foods as cow's milk, eggs, cereal, grains, nuts, fish, and chocolate, and such inhalants as house dust, pollens, feathers, animal danders, and atmospheric molds. Bacteria may be allergens, as may drugs and insects.

Other factors also are involved in the development of allergies, and "frequently the first attack of asthma appears following recovery from pertussis and sometimes, from measles."

Psychic conditions hold a controversial place as a cause of allergy, the article states, and numerous attempts to find consistent connections between personality patterns and specific allergic reactions have failed.

"In asthmatics, however, basic fear of separation from the mother, or mother figure, is frequently found on psychoanalysis."

How Can Allergies Be Managed?

Therapeutic Notes stresses the fact that "specific treatment (of allergies) consists of eliminating or avoiding the offending allergens, and hyposensitization."

Hyposensitization is used chiefly when the allergen is an inhalant, such as pollens, dusts and molds.

When a diagnosis of asthma is made, most authorities agree that the child should be desensitized as soon as possible, regardless of age.

Seasonal hay fever alone in the very young, especially if mild, can be controlled, but keeping the child under observation is important, because asthma may develop in patients not receiving specific treatment.

Many allergies can be suppressed with a variety of drugs. The antihistamines, useful in relieving most allergic conditions, have proved especially effective in treating pruritus, excessive secretions from the nose and eyes, and edema.

COMMON COLD MAJOR MEDICAL CAUSE OF SCHOOL ABSENCES IN SOUTH DAKOTA

The common cold continues to be the largest single factor contributing to the 15.8 days per school year the average South Dakota student is absent from school, according to a study by Schering Corporation, a leading pharmaceutical company.

Using statistics from the National Education Association, the study reveals that South Dakota ranks 18th in days attended per pupil. The best attendance record for the 1962-63 school year was set by the state of Washington with an average of 10.5 days missed. Utah was second with 11.2. The national average of school absences was 18.9.

Medical surveys indicate that children of elementary school age have five times as many colds as do adults. According to a 1963 U. S. Public Health Service report, respiratory illnesses were responsible for about two-thirds of school days lost because of acute illnesses or injuries during the 1961-62 school year.

The first onslaught of colds strikes the schools almost as soon as children reassemble for the new year. One contributing factor to this, according to research scientists, is that spread of colds like other virus-caused infections is accelerated by the mixing of populations. In fixed stable groups which are not exposed to strangers, cold-like infections tend to die out, and do not reappear until there is contact outside the group.

The best defense against the common cold is prevention. Warm clothing should be worn, and good diets planned. Whenever possible avoid contact with a person suffering from a cold.

Medicines, of course, are important. **A recent survey by a drug industry publication revealed that only one out of eight home medicine cabinets is fully equipped with products needed in common types of health situations arising in the home, such as the cold. The list of 11 "basic" supplies recommended includes: gargle, antihistamine-aspirin, cotton swabs, stomach settler, laxative, cough syrup, eye drops, decongestant, fever thermometer, bandages and an analgesic.**

Attendance Rank	State	Days Absent
16	Alabama	15.5
46	Alaska	26.5
45	Arizona	25.6
31	Arkansas	19.6
40	California	23.5
23	Colorado	17.2
12	Connecticut	14.8
4	Delaware	12.2
43	Florida	24.9
39	Georgia	23.4
22	Hawaii	16.8
20	Idaho	16.0
42	Illinois	24.6
37	Indiana	21.8
14	Iowa	14.8
	Kansas	*
30	Kentucky	19.2
25	Louisiana	18.0
6	Maine	12.5
	Maryland	*
27	Massachusetts	18.1
11	Michigan	14.4
8	Minnesota	14.0
41	Mississippi	24.2
44	Missouri	25.1
13	Montana	14.8
5	Nebraska	12.4
47	Nevada	52.0
21	New Hampshire	16.1
24	New Jersey	17.5
38	New Mexico	22.9
33	New York	20.6
15	North Carolina	15.3
7	North Dakota	13.5
3	Ohio	12.1
19	Oklahoma	15.9
32	Oregon	19.8
28	Pennsylvania	18.2
34	Rhode Island	21.5
35	South Carolina	21.6
18	South Dakota	15.8
17	Tennessee	15.7
29	Texas	19.1
2	Utah	11.2
	Vermont	*
26	Virginia	18.1
1	Washington	10.5
10	West Virginia	14.3
9	Wisconsin	14.3
36	Wyoming	21.6

* Data Unavailable

DANGER OF HOSPITAL STAPH IN HOMES

Three major medical journals in recent weeks have published articles which serve to warn physicians against the chain of infections which are causing "hospital epidemics" to spread into homes and communities.

The medical publications are **New England Journal of Medicine, Lancet,** and **Journal of the American Medical Association.**

The infections are those caused by antibiotic-resistant staphylococci, the so-called "hospital staph," which have been the infective agents in the chain of infection which runs from hospital-to-home-to-community. They cause boils, abscesses, and other skin afflictions and, occasionally, general or systemic infections which may lead to death.

Epidemic Outbreak

The August 15 issue of the **New England Journal of Medicine** published a report of a dramatic epidemic authored by three members of the medical and public-health faculties of the University of Pittsburgh. In this outbreak, a rare type of staphylococcal skin disease struck affecting 15 infants within 15 days last October.

Eleven of the cases were caused by staph types which had been identified in the nursery less than two weeks previously, two were caused by a type which had been cultured from noses and navels of babies in previous weeks.

The outbreak was quickly controlled by instituting a procedure of bathing all infants in all nurseries of the hospital with a 3 per cent hexachlorophene detergent. Mothers were instructed in the technique of hexachlorophene bathing, and were given to take home the bottle of the detergent skin cleanser (pHisoHex) which was used in the hospital to bathe their babies.

Prior to outbreak of the epidemic, only infants in the premature nursery of this institution — the Magee-Women's Hospital, Pittsburgh — had been given regular baths with the hexachlorophene detergent cream. However, all physicians, nurses, and other nursery personnel had been required to wash their hands with the antibacterial cleanser after handling each baby. Full-term babies were previously washed with water, in the body creases only.

To control the epidemic, simultaneously with the program of hexachlorophene bathing, infected infants were treated with antibiotics applied locally to skin lesions. Those with severe lesions received injections of methicillin as well as phisohex baths.

Nine of the cases were diagnosed on follow-up visits after discharge, but the type of bacteria indicated that their infections were of hospital origin.

The authors, Drs. Russell R. Rycheck, Paul M. Taylor, and Horace M. Gezon, comment: "The epidemic was remarkable in the early appearance of clinical manifestations, the severity and variety of the lesions and the rapid disappearance of the offending staphylococci . . . [They] could not be isolated from the newborn population 16 days after the first clinical disease appeared and 14 days after the entire nursery population was placed on daily hexachlorophene baths."

British Report

The **Lancet** article, August 15, 1963, an "annotation" or editorial, says: "Staphylococcal infections in hospitals seldom fail to make headline news . . . Staphylococci in the home have attracted less attention. Being inhabitants of the skin, these organisms can readily spread via the bath and the communal towel within a family and beyond." The British Journal has coined the name **staphyloccus domesticus** for this unwelcome visitor to the home.

"Staphylococcal lesions in the home are seldom more than skin deep — i.e., boils. But furunculosis can be a serious matter for the individual and even for the household . . . Occasionally the organisms erupt — or are driven — beyond their skin-deep follicles to cause metastatic lesions such as osteomyelitis or even septicemia. They can sometimes persist in the household as easily as in the hospital ward: We have heard of families . . . where a boil on the father's neck was followed by osteomyelitis and septicemia in one of his children.

"Management of this kind of infection requires detection, hygiene, and chemotherapy in that order . . . Antibiotics may be required if the lesions are extensive, but the usefulness of simple antiseptics and lotions to control skin colonization should not be overlooked."

Staph in the Community

The **J.A.M.A.** article appeared in the July 20, 1963, issue. The report concerns an epidemiological study of a detached community of married graduate students with a high proportion of young children. Most of the families used a community laundry, many visited often in each other's homes, especially children.

Of families with children, 31 per cent had had staph infections; but only 10 per cent of those who had no children. Mothers ranked highest as staph carriers, but the over-all carrier rate for the community was uncommonly high. The epidemiological conclusions: (1) Hospital nurseries were the origin of the staph infections which came home with the newborn baby. (2) Housekeeping and laundry practices perpetuated and redistributed the bacteria.

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DRUG TRAVELERS COOPERATE WITH JOURNAL

Through recent arrangements with the Allied Drug Travelers Association of South Dakota that organization has become an active participant in contributing to and supporting **This Journal.** There are presently about 35 members of the group who are now subscribers and who will be making contributions to succeeding issues. We are happy to have them join our midst and welcome and appreciate their support.

Pharmacists of South Dakota are, of course, much interested in the activities of the drug travelers, just as they are in those of the pharmacists. We hope, and feel that through this new association there will emerge an even closer and more effective relationship between the two groups.

Instrumental in effecting this arrangement is Travelers' Secretary, **Jim Drey.** His address is 1632 Frederick Drive, Sioux Falls, S. D., and we know that he will welcome correspondence from the members of his organization as well as that from the pharmacists of the State. The pharmaceutical office of **The Journal** extends the same welcome.

Modern new pharmacy in northern Wisconsin tourist area, doing a 38 per cent more business than '62; heart of fishing and resort area. Growing city of 3,000; 6 doctors in area, new hospital; low overhead; $100,000 gross. Own building, terms. Retiring reason for selling. Present location 75 years. A real buy. Write Box A5, South Dakota Journal of Medicine, 711 N. Lake Avenue, Sioux Falls, South Dakota.

MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS

(The Squibb Review, April, 1963)

A great deal is being said these days about the value of membership in pharmacy's professional associations. Pharmacists have not supported their organizations in anything like the way that members of their sister professions do. Physicians and dentists, almost to a man, belong to their societies.

The major reason pharmacists give for nonmembership is stated in a question, "What do I get out of it?" The answer, they seen to feel, is "very little."

Wilkins Harden, immediate past president of the American College of Apothecaries, points out the error in their negative attitude with the following quotation:

> "If you have a dollar and I have a dollar, and we exchange — we still have a dollar. But if you have an idea and I have an idea, and we exchange, we each have doubled our ideas. That's the kind of profitable exchange you benefit from when you actively participate in your professional associations."

A BRIEF ANALYSIS OF H.R. 7247 BY THE ANIMAL HEALTH INSTITUTE

Congressman Roberts (D., Ala.) introduced H.R. 7247 on June 25, 1963. The bill amends the Federal Food, Drug, and Cosmetic Act by consolidating in a separate section the provisions assuring the safety and effectiveness of new animal drugs. It embodies the proposals for needed legislative change which the Animal Health Institute has advocated for a considerable period. Congressmen Hull (D., Mo.) and Nelsen (R., Minn.) introduced identical bills—H.R. 7250 and H.R. 7251, respectively.

The Federal Food, Drug, and Cosmetic Act has been amended on a number of occasions. The purposes of these various amendments have had little or nothing to do with animal drugs. H.R. 7247 is specifically aimed at the regulation of animal drugs and particularly at the requirements for premarketing clearance of new animal drugs by the Food and Drug Administration. It, thus, gives legislative consideration which has been long overdue to these drug products and to the whole field of veterinary medicine, without, in any way, lessening the standards of safety and effectiveness which these drugs have been required to meet. With a new section, 511 — a single procedure for the clearance of "new animal drugs" — H.R. 7247 replaces the cumbersome premarketing clearance structure which accident and indirection have imposed on new and animal drugs.

In 1938, the new drug section of the Act, section 505, as we know it today, was enacted in response to a critical need for certainty concerning the safety of human drugs. In 1946 the antibiotic certification section was added to the Act in response to a well-defined need for certainty as to quality, purity, and stability of the important new human medicinal agent penicillin. The veterinary applications of penicillin were unknown at the time of the amendment. In 1958 the Food Additives Amendment to the Act was passed to regulate the use of direct intentional additives to the human food supply. However, each of these amendments has had a significant impact upon new animal drugs. This has been due to the statutory language used in certain of the amendments and to administrative interpretations given these provisions of the Act. As a consequence, new animal drugs have had to secure individual clearances under the new drug, antibiotic certification, and food additive sections of the Act instead of from only one section as in the case of human medicines.

New animal drugs have contributed significantly to improved livestock and poultry production in recent years. These drugs in combination with certifiable antibiotics are administered to much of the nation's livestock and poultry populations in the feed rations. This combination of feed, certifiable antibiotic, and new drug, required for disease prevention and growth promotion, presently must obtain triplicate clearances from the Food and Drug Administration.

H.R. 7247 effects a further procedural streamlining of the Act by eliminating the requirement that feed mills secure supplemental new drug applications for animal drugs which have already been demonstrated by the drug manufacturers to be safe and effective. The bill, of course, contemplates that each feed manufacturer must meet the good manufacturing practice regulations authorized by the 1962 amendments to the Act.

We in A.H.I. believe that H.R. 7247, if enacted, will have material benefits for livestock and poultry producers. By reducing the procedural superstructure through which new animal drugs must now find their way, without reducing the standards for safety and effectiveness of such drugs, an increased rate of flow of important new animal medicinal agents should follow — medicinal agents which will be of use in feed supplementation and in veterinary therapeutics. H.R. 7247 puts authority over animal drugs in a single section of the Act — not scattered throughout the law as it exists today. It would, therefore, have the effect of bringing new animal drugs from the laboratory to the farm more expeditiously.

PRESIDENT'S PAGE



We all know that pharmacy in South Dakota, as well as throughout the nation, has and is continuing to face many critical issues which are of vital importance to all of us.

We are also aware of the fact that our annual state conventions permit us only a limited amount of time to discuss and act upon these issues.

Therefore, my message to you this month is simply this: if you have any problems or suggestions that you feel should be discussed, please submit them to me so that they may be considered by the Executive Committee prior to our annual meeting. I feel that, in this way, we can better utilize our convention time.

Your cooperation will be most gratefully appreciated.

Sincerely,

Wayne C. Shanholtz
President



VISITORS TO THE OFFICE

Among the recent visitors to the pharmaceutical office of **The Journal** was **Wayne Dyball,** formerly of Volga and presently associated with Revco, Inc., of Cleveland, Ohio. Dyball was recently made vice president in charge of store operations for the Ohio drug chain. He spent several days in South Dakota and surrounding area visiting relatives and friends. He is a 1938 graduate of the Division of Pharmacy of South Dakota State College.

NEWS ITEMS FROM THE ALLIED DRUG TRAVELERS

Quarterly Meeting Held: The Westward Ho Country Club, Sioux Falls, was the site of the quarterly meeting of the Allied Drug Travelers Association on September 14.

Election of Officers: A principal item of business at the quarterly meeting was the election of new officers for the coming year. Named president was **Don Alfred,** Mitchell; first vice president, **Don Dravland,** Mitchell; and second vice president, **W. J. Agnitsch,** Sioux Falls. Executive Board members elected were **Warren Kemp, William J. Couch** and **Cliff Sumption.** The offices of secretary and treasurer are permanent offices of the Association. These are held by **James Drey,** Sioux Falls, and **Clarence Barr,** Brookings, respectively.

Directory to be Published: Members of the Association approved the composing and publishing of a State Drug Travelers Directory. This is to be distributed to all drug stores, wholesalers, and hospital and clinic pharmacies in South Dakota.

New Members: New members to join the Allied Drug Travelers recently are **Jack Johansson,** Sioux Falls (McKesson & Robbins, Inc.); **Dennis Outka,** Sioux Falls (Wm. H. Rorer, Inc.); and **Gene Edison,** Aberdeen (Wm. S. Merrell Co.).

Social Committee: A social committee was named to promote social activities for members and their wives. The committee will also cooperate with the South Dakota Pharmaceutical Association in planning and conducting social events for the annual conventions. Chairman of the committee is **W. J. Agnitsch.** Members are **Merlyn Albaugh, Allen Whitson, Donald Barr** and **Dennis Outka.**

New Constitution: A new constitution and set of by-laws have been adopted by the Association and are currently in the process of being printed. The Allied Drug Travelers Association wishes to acknowledge, with appreciation, the cooperation of Brown Drug Company, Sioux Falls, for its help in printing these and the Directory.

Secretary's Note: Anyone interested in membership in the Allied Drug Travelers Association, should contact **James Drey,** secretary, 1632 Frederick Drive, Sioux Falls, S. D.

Happy Thanksgiving to all pharmacists, physicians and members.

ADMISSIONS TO THE DIVISION OF PHARMACY SHOW INCREASE

Eighty new students were admitted to the Division of Pharmacy, South Dakota State College, for the fall semester, 1963. This is an increase of approximately ten over admissions for the fall quarter of 1962. Of the new students, 64 were admitted as freshmen, i.e., directly from high school, while the remaining 16 presented transfer credits. Total enrollment in the Division is 218.

The student body is distributed over four classes. Because of the transfer from the four-year program to the five-year program, which was initiated in the fall of 1960, there is no fifth year class and, consequently, there will be no pharmacy graduates at the conclusion of the current academic year.

AUGUSTANA GRADUATE NAMED TO MINNEAPOLIS UPJOHN SALES POST

J. C. Berthel, 1951 graduate of Augustana College, has been appointed to the post of divisional sales manager of The Upjohn Company's Minneapolis branch.

Berthel joined the Company in March, 1954, and was assigned to the Mattoon, Illinois, territory. He was appointed sales supervisor for the Southern Illinois District in January, 1959. In March, 1961, he was transferred to the home office in Kalamazoo, Michigan, and was assigned to the sales education staff.

HAROLD MILLS HONORED BY ROBINS COMPANY

Harold W. Mills, Rapid City, 1963 winner of the A. H. Robins' "Bowl of Hygeia" award, was honored by the Robins Company in a visit to the Robins Plant and Laboratories in Richmond, Virginia, and in an appearance in a "Salute to Pharmacy" ad in **Time** magazine.

Mr. Mills was a guest of the Company and its president, E. Claiborne Robins on October 10-12. He is one of 49 "Bowl of Hygeia" recipients, including four from Canada, invited to Richmond in a group as a recognition of service to their respective communities and to honor them during National Pharmacy Week.

While in Richmond, the group toured the Robins Plant and Laboratories and was entertained at a reception and dinner.

Each of the 1963 "Bowl of Hygeia" recipients appeared in the Company's full-page "Salute to Pharmacy" advertisement in the October 6 issue of **Time.**

THOMPSON NAMED TO BOARD OF PHARMACY

Carveth Thompson, 31, owner of the Thompson Drug Store, Faith, was recently named to the South Dakota Board of Pharmacy by **Governor Archie Gubbrud.** He succeeds retiring member **Ted Hustead,** Wall, and joins incumbent members **Roger Eastman,** Platte, and **Tom Haggar,** Watertown.

Thompson is a 1954 graduate of the Division of Pharmacy, South Dakota State College, and served in the armed forces in Japan prior to his present practice in South Dakota.

MEETING DATES FOR DISTRICT V BOARDS AND COLLEGES SET

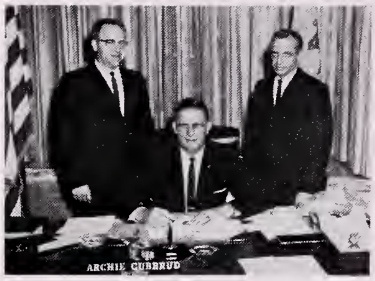
The 1964 meeting of District V of the National Association of Boards of Pharmacy and the American Association of Colleges of Pharmacy has been scheduled for Minneapolis, Minn., September 26-28 or, alternately, September 27-28. Headquarters for the meeting will be the Capp Towers Motor Inn. Co-chairmen are **William Apple,** for the Boards, and **Hugh Kabot** for the Colleges.

South Dakota will be the host state for the 1965 meeting. The location and dates have not been set but the co-chairmen for the event will be **Tom Haggar** and **Guilford Gross,** representing, respectively, the Boards and Colleges.

The 1966 meeting will be held in North Dakota.

The most recent meeting of the two organizations was held in Iowa City, Iowa, September 29-30, 1963. Attending the meeting, from South Dakota, were **Dean F. J. LeBlanc** and **Dr. Gary Omodt** of Brookings; **Roger Eastman,** Platte; **Tom Haggar,** Watertown; **Ted Hustead,** Wall; **Carveth Thompson,** Faith; and **Harold Schuler,** Pierre.

District V is comprised of Iowa, Minnesota, Nebraska, North Dakota and South Dakota.



Governor Gubbrud signs National Pharmacy Week proclamation. Standing, at his right, is Harold Schuler, director of public relations for the South Dakota Pharmaceutical Association, and, on his left, is James Rogers, Pierre pharmacist.

NATIONAL PHARMACY WEEK RECEIVES WIDE RECOGNITION THROUGHOUT STATE AND AREA

Governor Signs Proclamation

Governor Archie Gubbrud proclaimed National Pharmacy Week October 6-12 by issuing a signed proclamation stating that the 600 pharmacists in the 240 drug stores in the State are indispensable members of the health profession. He further urged all residents to observe the vital role of the pharmacist upon whose skill and training all citizens so largely depend.

Pharmacy Faculty Participates in Observances

In recognition of National Pharmacy Week, the faculty of the Division of Pharmacy, South Dakota State College, sponsored a television program October 9, which was carried simultaneously by channels 11 (Sioux Falls), 3 (Garden City) and 9 (Reliance). Appearing on the program were **Dean F. J. LeBlanc** and two fourth-year pharmacy students, **Shirley Roso** of Watertown and **Jeanne Myron** of Mankato, Minnesota.

Twenty-five radio stations in the Minnesota-North Dakota-South Dakota area carried Pharmacy Week programs on October 8. **Dr. Gerald Bruno,** assistant professor of pharmaceutical chemistry, was a participant in these programs.

Local newspapers carried feature articles on the Division of Pharmacy in recognition of the occasion.

Dr. Kenneth Redman, professor of pharmacognosy, was the coordinator for the various public relations activities.

ASHP ELECTS PRESIDENT AND BOARD MEMBERS

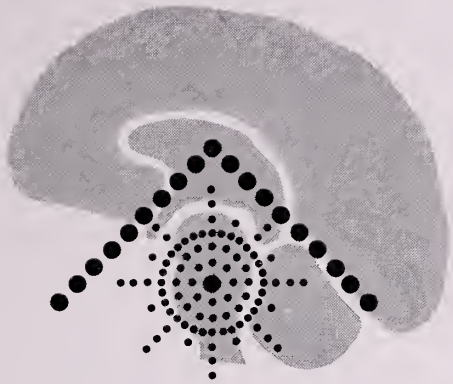
William W. Tester, director of hospital pharmacy services at the University of Iowa Hospitals and assistant professor, University of Iowa School of Pharmacy, Iowa City, is president-elect of the American Society of Hospital Pharmacists. He and six elected members of the Board of Directors will be installed at the final session of the 1964 annual meeting to be held in conjunction with the annual meeting of the American Pharmaceutical Association in New York City during the week of August 2.

The members-elect to the Board of Directors are: **Louis P. Jeffrey,** Albany Medical Center Hospital, Albany, New York, and **Clifton J. Latiolais,** University Hospital, Ohio State University, Columbus, both for three-year terms; **Sister Mary Vera Rourke,** Mercy Hospital, Buffalo, New York, and **Peter Solom, Jr.,** Palo Alto-Stanford Hospital Center, Palo Alto, California, for two-year terms and **Herbert S. Carlin,** University of Illinois at the Medical Center, Chicago, and **Robert A. Statler,** Veterans Administration Pharmacy Service, Washington, D. C., for a one-year term.

FORMER SOUTH DAKOTAN DIES IN CALIFORNIA

Captain Jon T. Hammer, 28, hospital administrator at Edwards Air Force Base, California, died September 28 of complications following heart surgery. Born in Yankton and raised in Plankinton, Captain Hammer was a 1956 graduate of the Division of Pharmacy, South Dakota State College. He was the son of the late Victor Hammer and Mrs. Gladys Hammer of Los Angeles, California. Victor Hammer was superintendent of the State Training School in South Dakota for many years and Mrs. Hammer was director of education in the Sioux Falls Public Schools for two years.

Captain Hammer is survived by his wife, the former Virginia Loges, and three children.



in visceral motor disorders...

EASIER MANAGEMENT

When emotional disturbance is a significant factor in dysfunction of gastrointestinal tone, motility and secretion, Pro-Banthine with Phenobarbital provides the dual activity that leads to easier management of both the patient and his problem:

Pro-Banthine (propantheline bromide) to neutralize the effect of excitatory impulses at visceral end organs, *and*

Phenobarbital to moderate emotional incitement centrally.

Pro-Banthine with Phenobarbital is indicated when a mild to a moderate psychic element is a factor in: Peptic ulcer • Biliary dyskinesia • Pylorospasm • Intestinal hypermotility • Spastic colon • Gastritis • Other dysfunctions of the gastrointestinal tract.

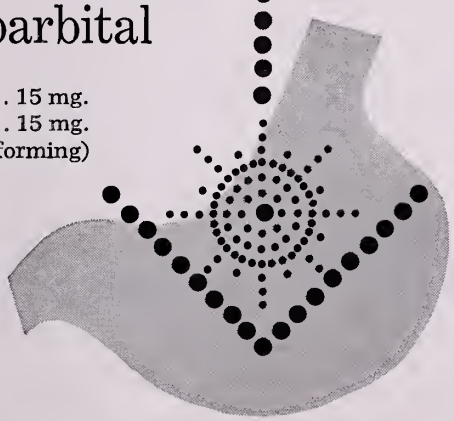
Dosage: One tablet four times a day.

Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action might occur with Pro-Banthine (brand of propantheline bromide). It is contraindicated in the presence of glaucoma or severe cardiac disease. The usual precautions with regard to phenobarbital should be taken.

G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine

PRO-BANTHINE®
with Phenobarbital

Each tablet contains:
propantheline bromide .. 15 mg.
phenobarbital ..... 15 mg.
(Warning: May be habit forming)



blood, milk and Maalox®

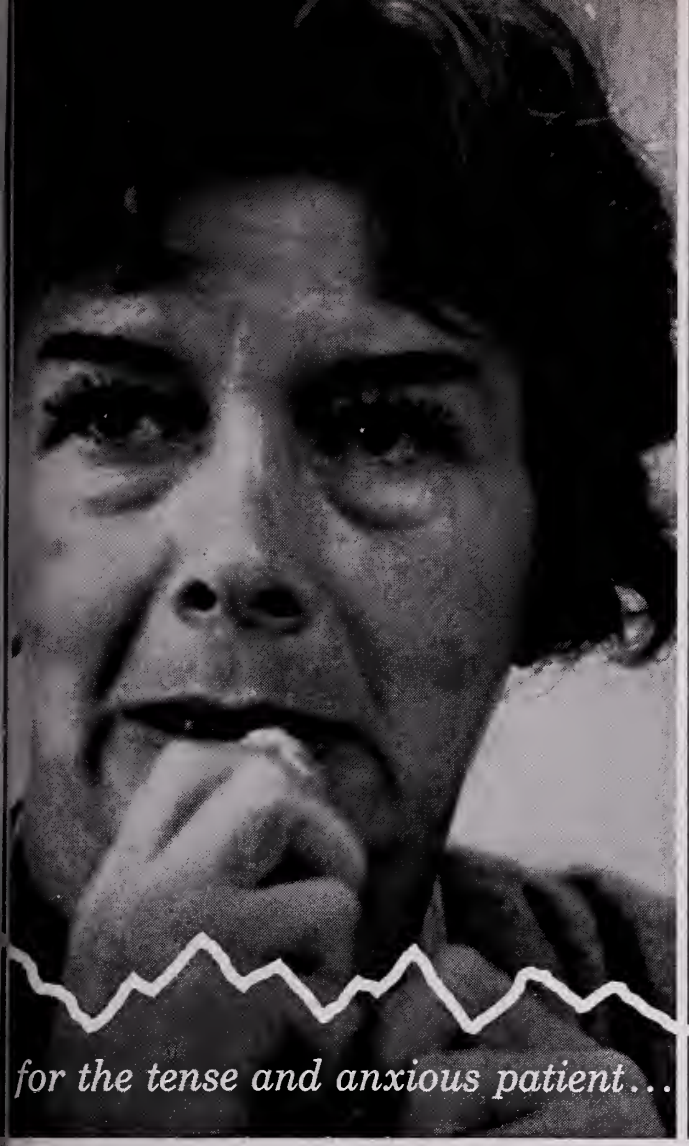
(magnesium-aluminum hydroxide gel)

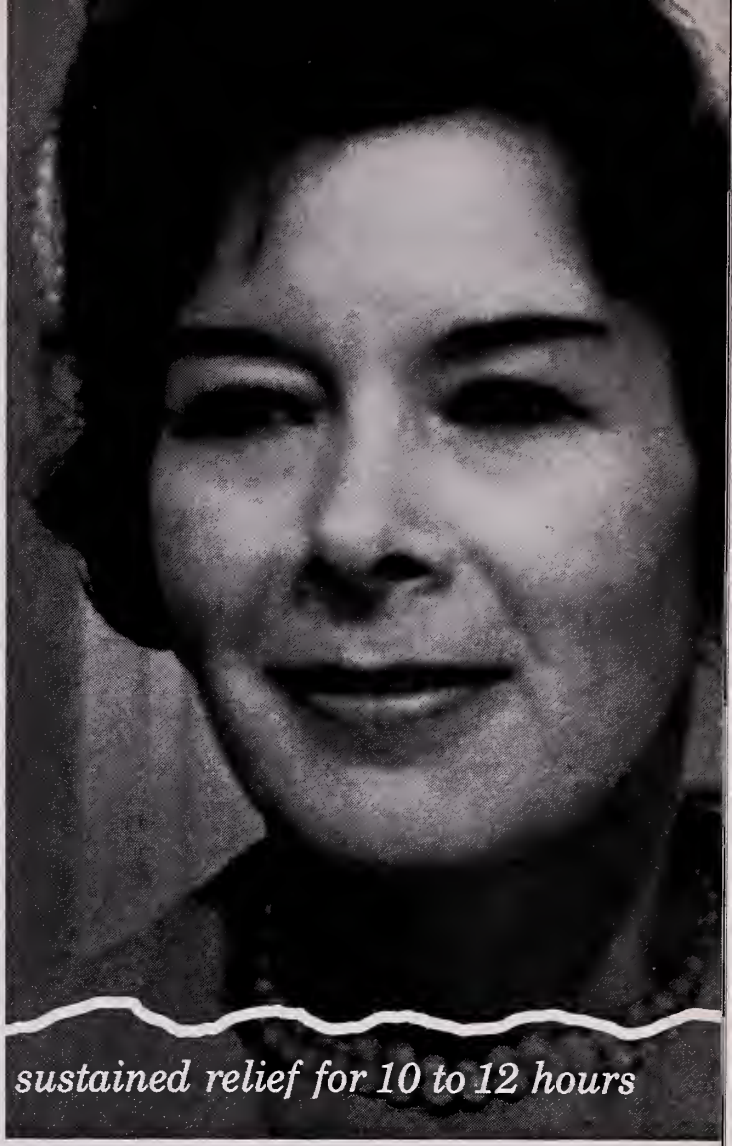
Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



ROHER

WILLIAM H. RORER, INC., FORT WASHINGTON, PA.





Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours — and provides these other advantages:

1. **Especially suitable for maintenance therapy.** Patients whose anxiety has diminished to a mild or moderate level still require a certain amount of tranquilization throughout the day. Sustained-release action is ideally suited to this type of patient.
2. **Simpler dosage schedule.** Since one capsule of 'Meprospan'-400 (meprobamate, sustained release) acts 10 to 12 hours, the patient enjoys a much simpler dosage schedule than with tablets – and is less likely to forget to take the medicine.

Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

Available: *'Meprospan'-400* (meprobamate, sustained release) contains meprobamate 400 mg. *'Meprospan'-200* (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. **Usual dosage:** One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Meprospan®-400
meprobamate 400 mg.
sustained release

WALLACE LABORATORIES / *Cranbury, N.J.*

CME-9188

Colds haven't changed— but relief has with NTz® NASAL SPRAY

NTz Nasal Spray gives on-the-spot relief for stopped-up noses instantly. Recommended by doctors for 10 years, it provides not one, but three powerful ways to fast relief.

In a carefully balanced formula, NTz contains:

Neo-Synephrine® HCl to shrink swollen nasal tissues and provide enough space for breathing

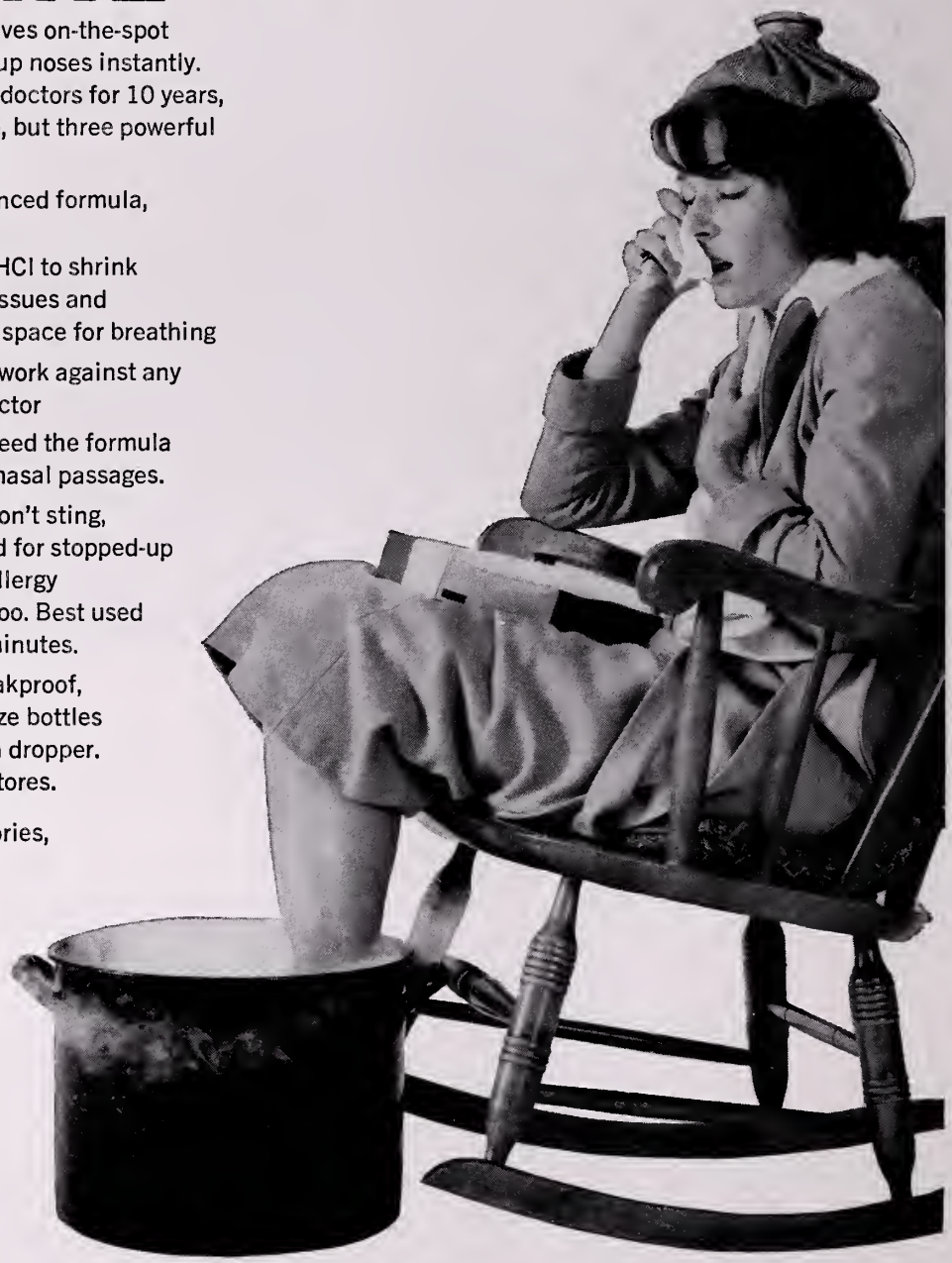
Thenfadil® HCl to work against any local allergic factor

Zephiran® Cl to speed the formula through **all** the nasal passages.

NTz Nasal Spray won't sting, won't irritate. Good for stopped-up noses caused by allergy and for sinusitis, too. Best used **twice** within five minutes.

NTz supplied in leakproof, pocket-size squeeze bottles and in bottles with dropper. Sold only in drugstores.

Winthrop Laboratories, New York 18, N. Y.



Winthrop

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.



STARTING TOMORROW MORNING 

this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule®

Trademark brand of sustained release capsules

Each No. 2 capsule contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F *Prescribing information Jan. 1963*



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

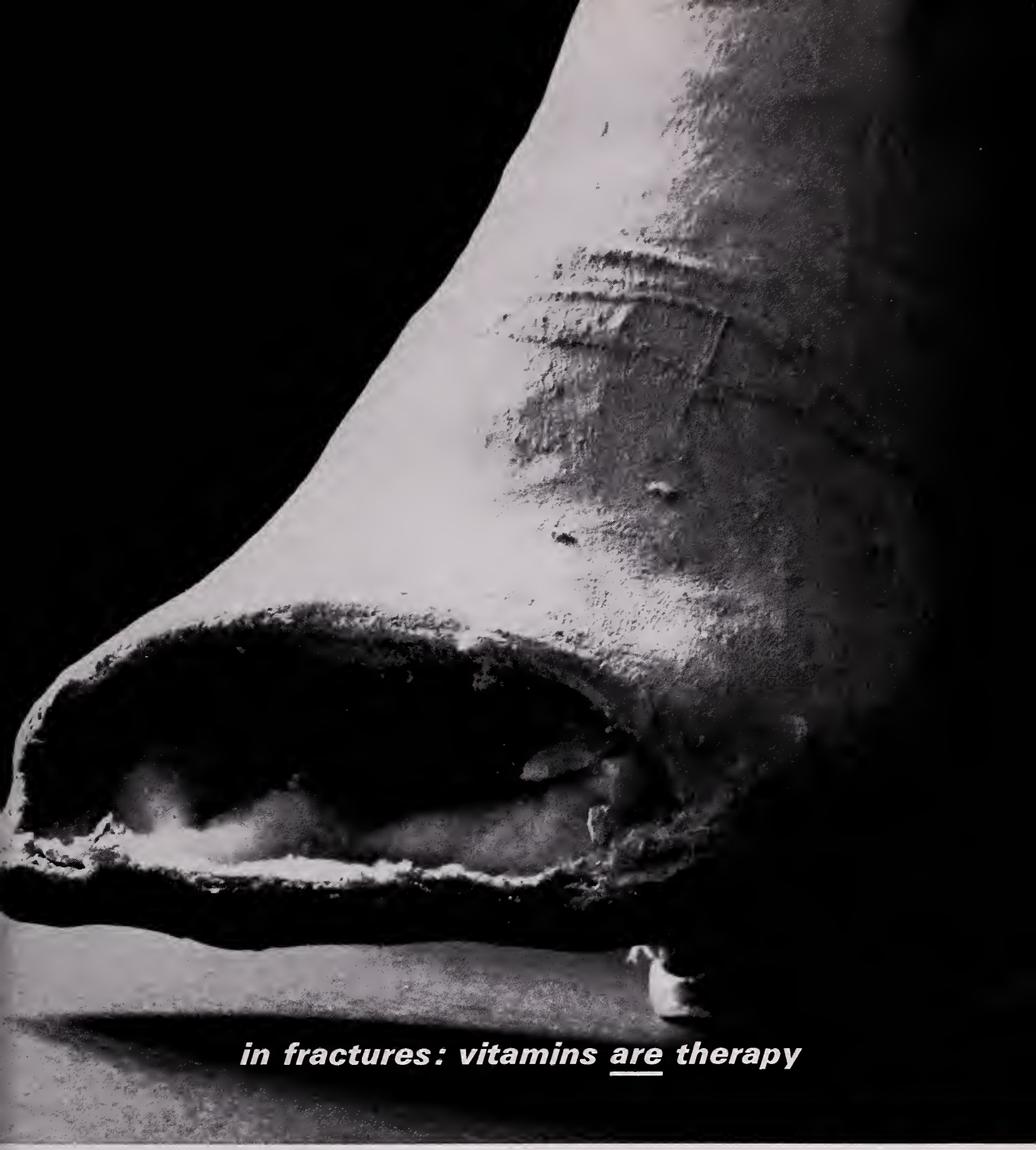
carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193



in fractures: vitamins are therapy

Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery.

FOR PROFESSIONAL

RECOMMENDATION ONLY

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide...100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline...4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6317-3

STRESSCAPS®

Stress Formula Vitamins Lederle

"What type of drug is both a tranquilizer and a muscle relaxant?"

"a tranquilaxant."

TRANCOPAL®
brand of
chlormezanone
is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone-Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers. Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties of this drug provide an extra dimension of effectiveness... relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of this true "tranquilaxant" is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlormezanone-Winthrop), such as occasional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

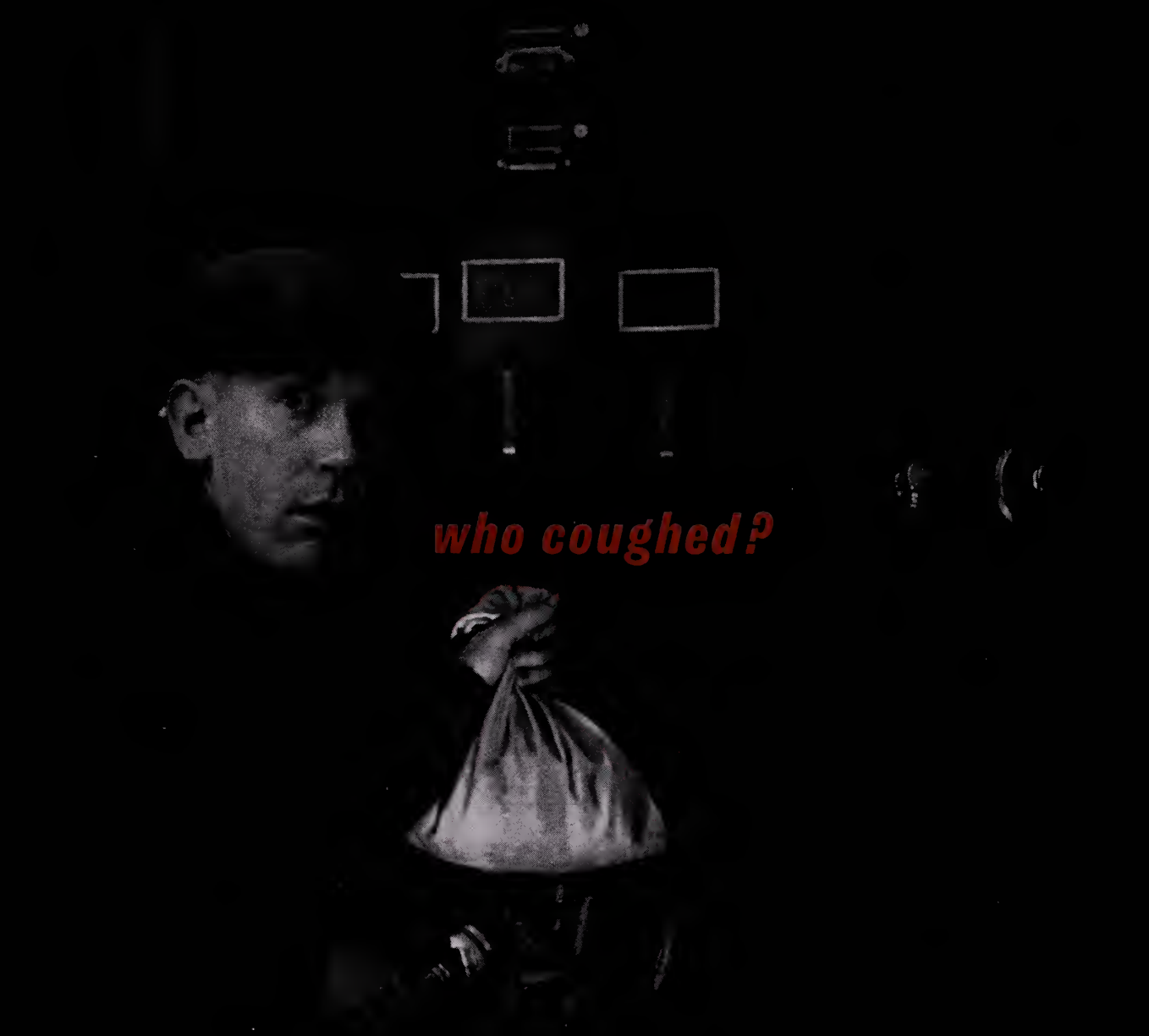
Available: 200 mg. Caplets® (green colored, scored). 100 mg. Caplets (peach colored, scored), each in bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Reference: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963.

1812M

Winthrop
WINTHROP LABORATORIES
New York, N.Y.



for fast and long-lasting cough control

HYCOMINE SYRUP

Each teaspoonful (5 cc.) contains:

Hycodan®	
Hydrocodone bitartrate . . 5 mg. (Warning: May be habit-forming)	6.5 mg.
Homatropine methylbromide 1.5 mg.	
Pyrilamine maleate	12.5 mg.
Phenylephrine hydrochloride	10 mg.
Ammonium chloride	60 mg.
Sodium citrate	85 mg.

in a highly palatable, cherry-flavored vehicle (methylparaben 0.13% and propylparaben 0.02% as preservatives)

INDICATIONS: For both productive and nonproductive cough. For relief of symptoms in tracheitis, bronchitis, pneumonia, pharyngitis, bronchial asthma, pertussis, and allied conditions; cough associated with allergy; in general, whenever cough medication is indicated.

DOSAGE: Average adult dose—1 teaspoonful after meals and at bedtime with food. Children 6 to 12 years, ½ teaspoonful; 3 to 6 years, ¼ teaspoonful; 1 to 3 years, 10 drops; 6 months to 1 year, 5 drops; after meals and at bedtime. On oral Rx where state laws permit. U.S. Pat. 2,630,400.

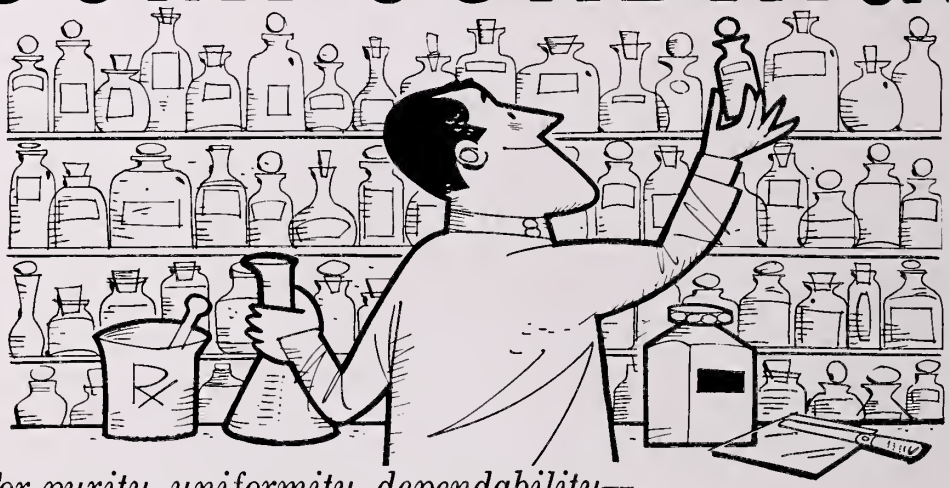
CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine HCl and in patients with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients use should not exceed three days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur. May be habit-forming.

Endo®

Literature on request

ENDO LABORATORIES Richmond Hill 18, New York

COMPOUNDING?



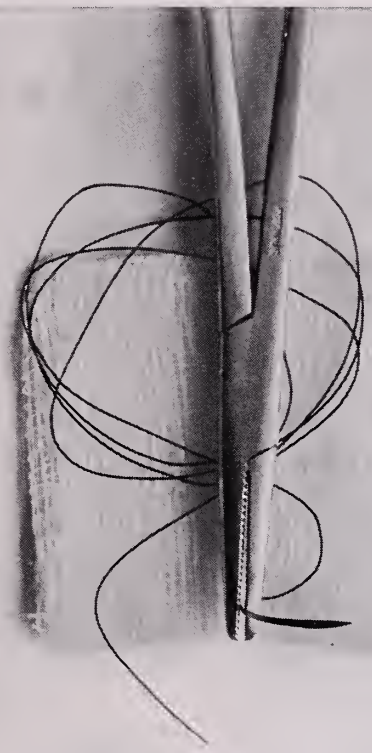
For purity, uniformity, dependability—
For delivery of what you want, when and where you want it—

CALL US FOR MERCK PRESCRIPTION CHEMICALS AND NARCOTICS

SOUTH DAKOTA

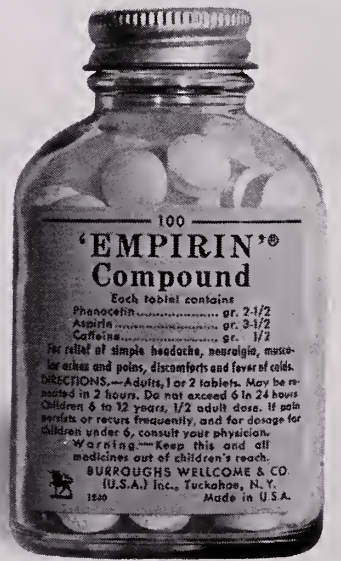
BROWN DRUG COMPANY	SIOUX FALLS
JEWETT DRUG COMPANY	ABERDEEN

Merck Chemicals are Distributed by
QUINTON COMPANY, Rahway, N. J., Division of MERCK & CO., INC.



In trauma, whether it's sutures, plaster, splint or sling...

remember 'Empirin' Compound to relieve pain



Also: 'Empirin'® Compound with Codeine Phosphate*
gr. ⅛—No. 1/gr. ¼—No. 2/gr. ½—No. 3/gr. 1—No. 4
*Warning—may be habit forming

why does 150 mg.



do more than 250 mg.



of other tetracyclines?

Because it has up to 3½ times the *in vitro* antibacterial activity[1]...combined with lower rate of decay in serum, slower renal clearance...a favorable depot effect, resulting from protein binding...all providing rapid, higher and sustained *in vivo* activity with as much as 2 days' extra activity.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

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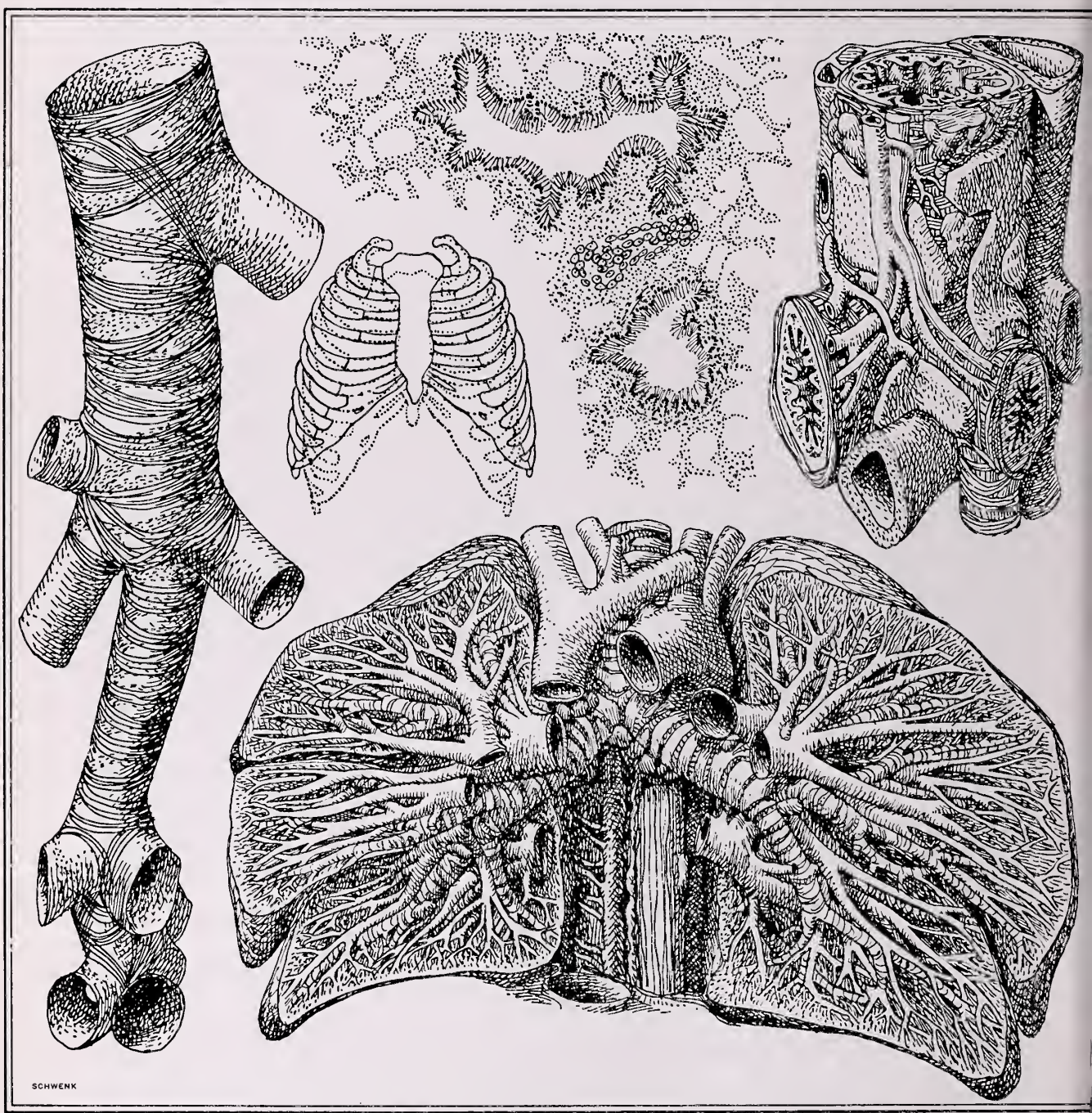
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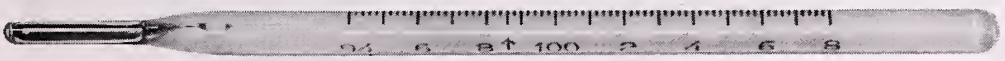
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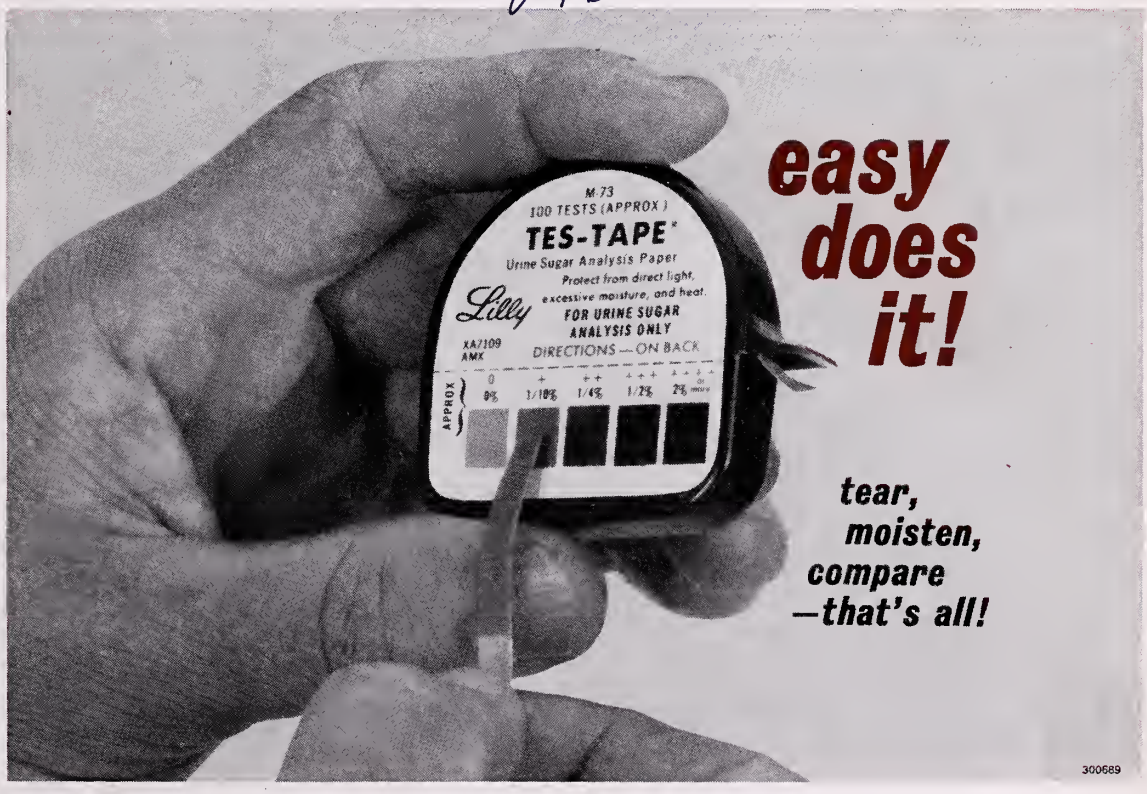
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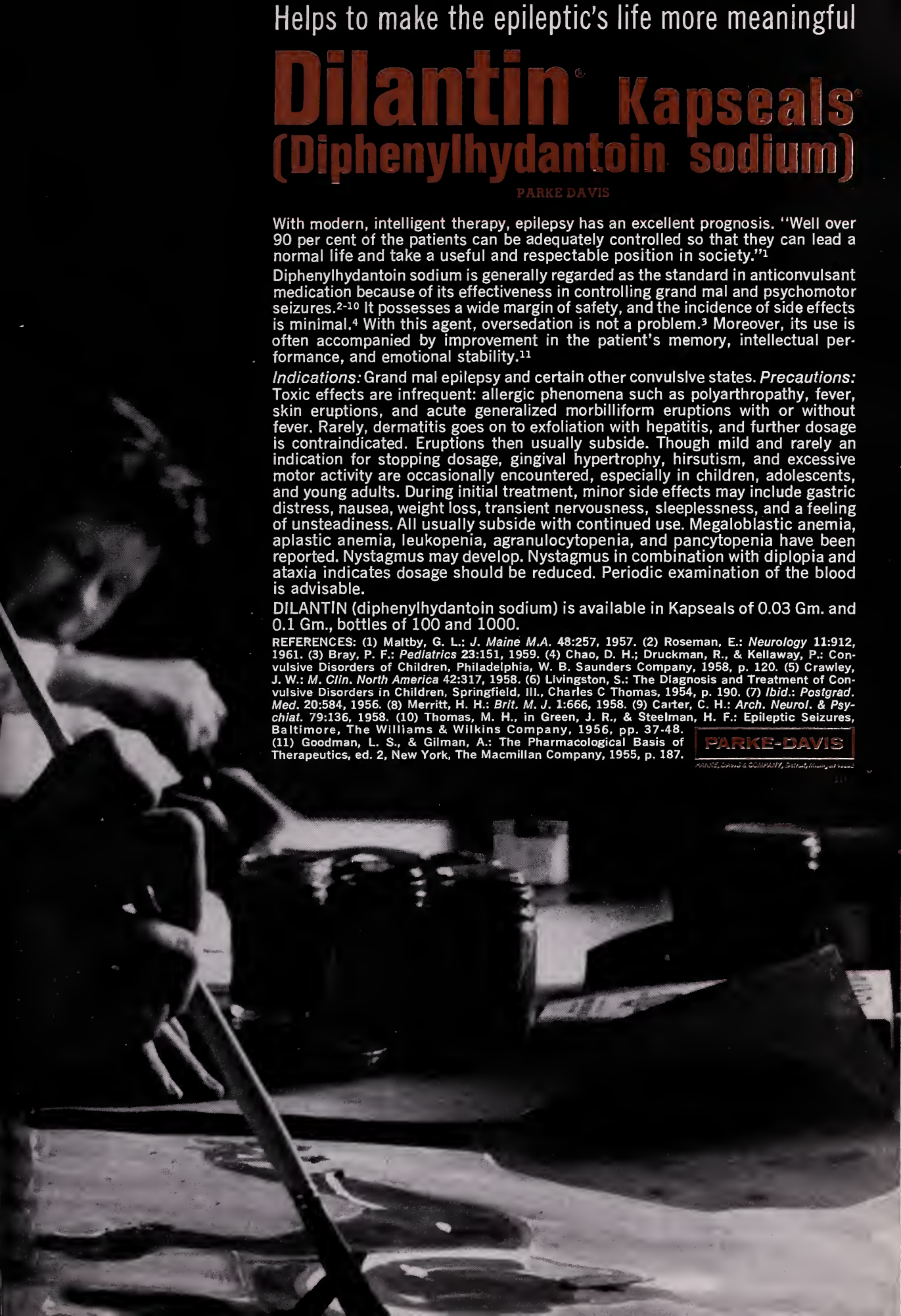
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REFERENCES: (1) Maltby, G. L.: *J. Maine M.A.* 48:257, 1957. (2) Roseman, E.: *Neurology* 11:912, 1961. (3) Bray, P. F.: *Pediatrics* 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: *M. Clin. North America* 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) *Ibid.*: *Postgrad. Med.* 20:584, 1956. (8) Merritt, H. H.: *Brit. M. J.* 1:666, 1958. (9) Carter, C. H.: *Arch. Neurol. & Psychiat.* 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

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Volume XVI **December, 1963** **Number 12**

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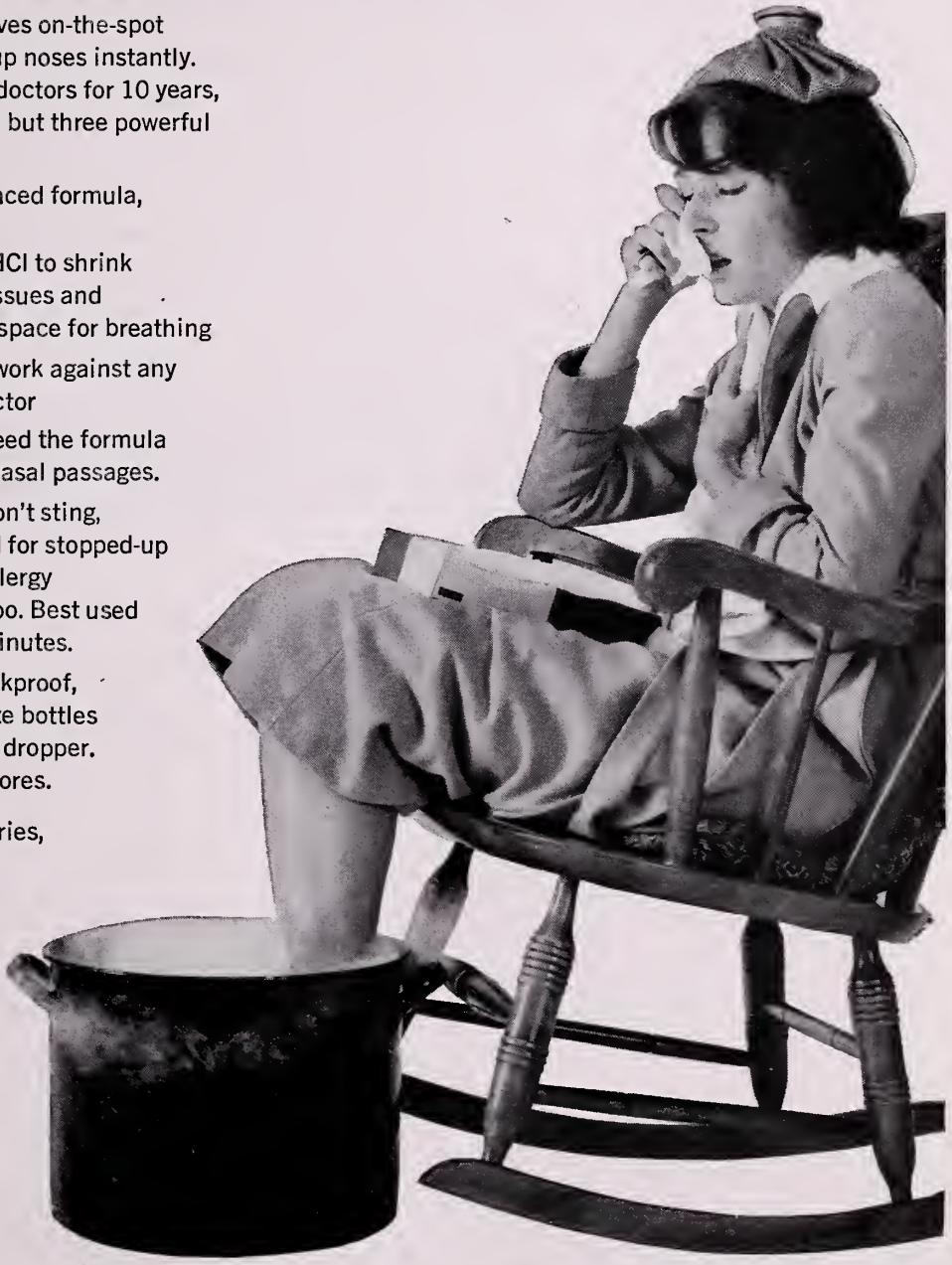
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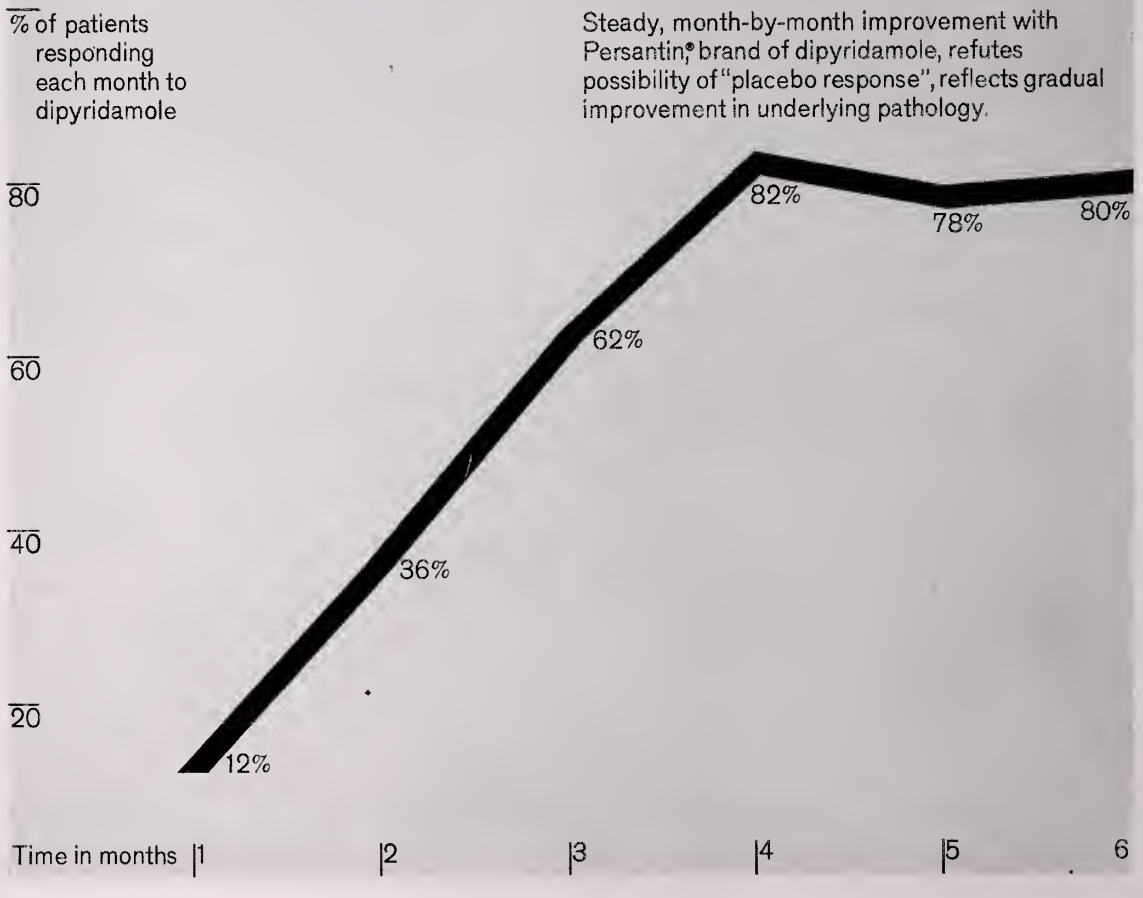
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Griep,A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:
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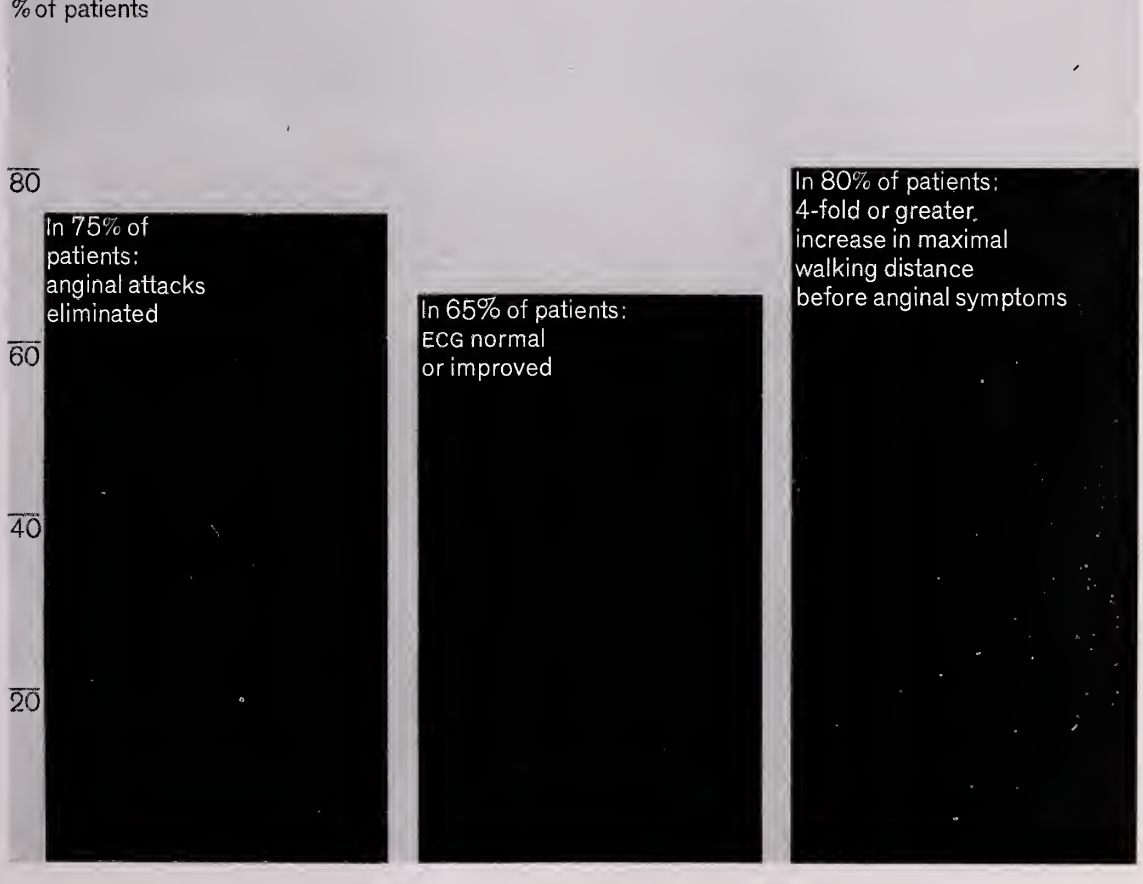
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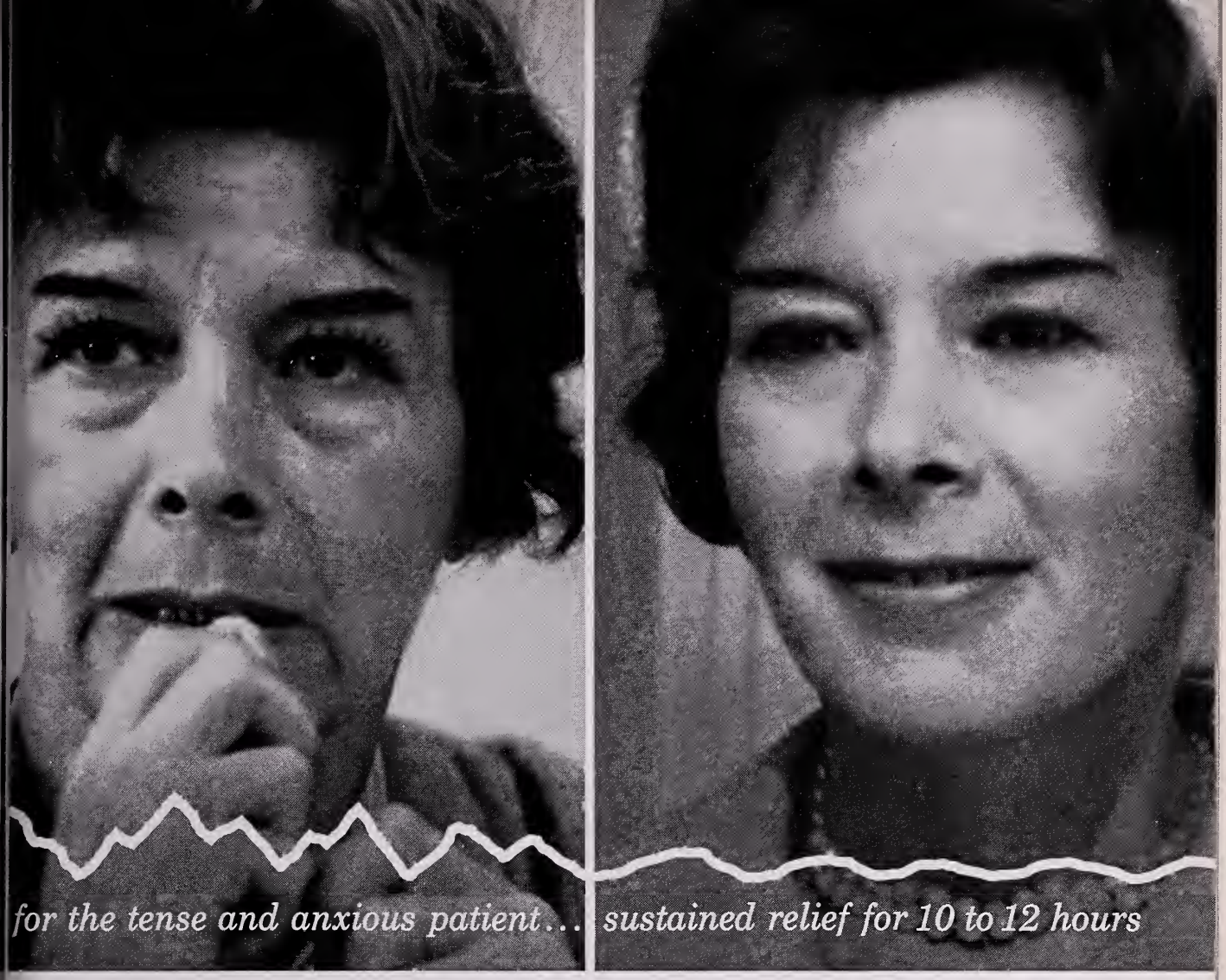
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References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.,et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.26:849,1962.

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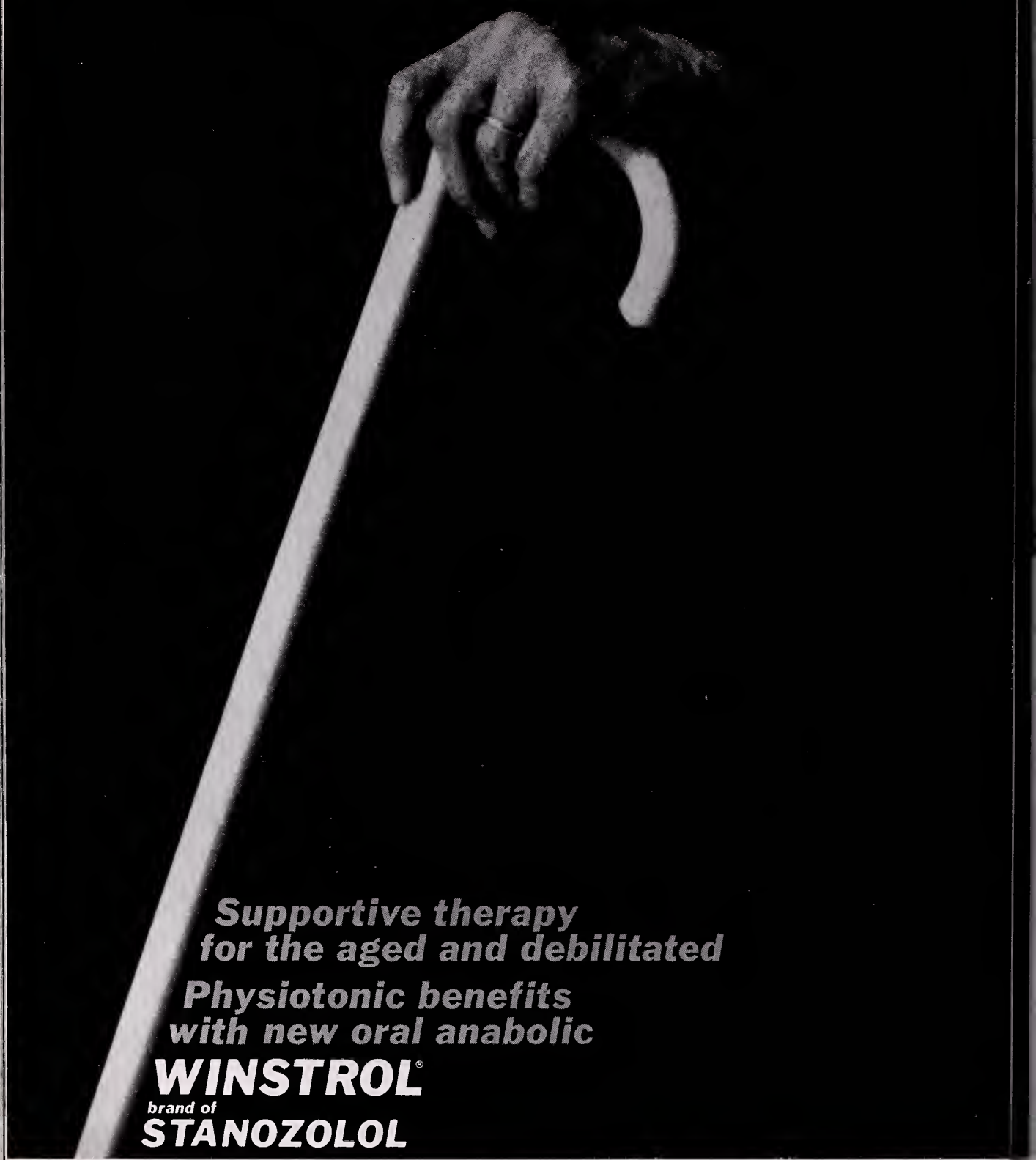
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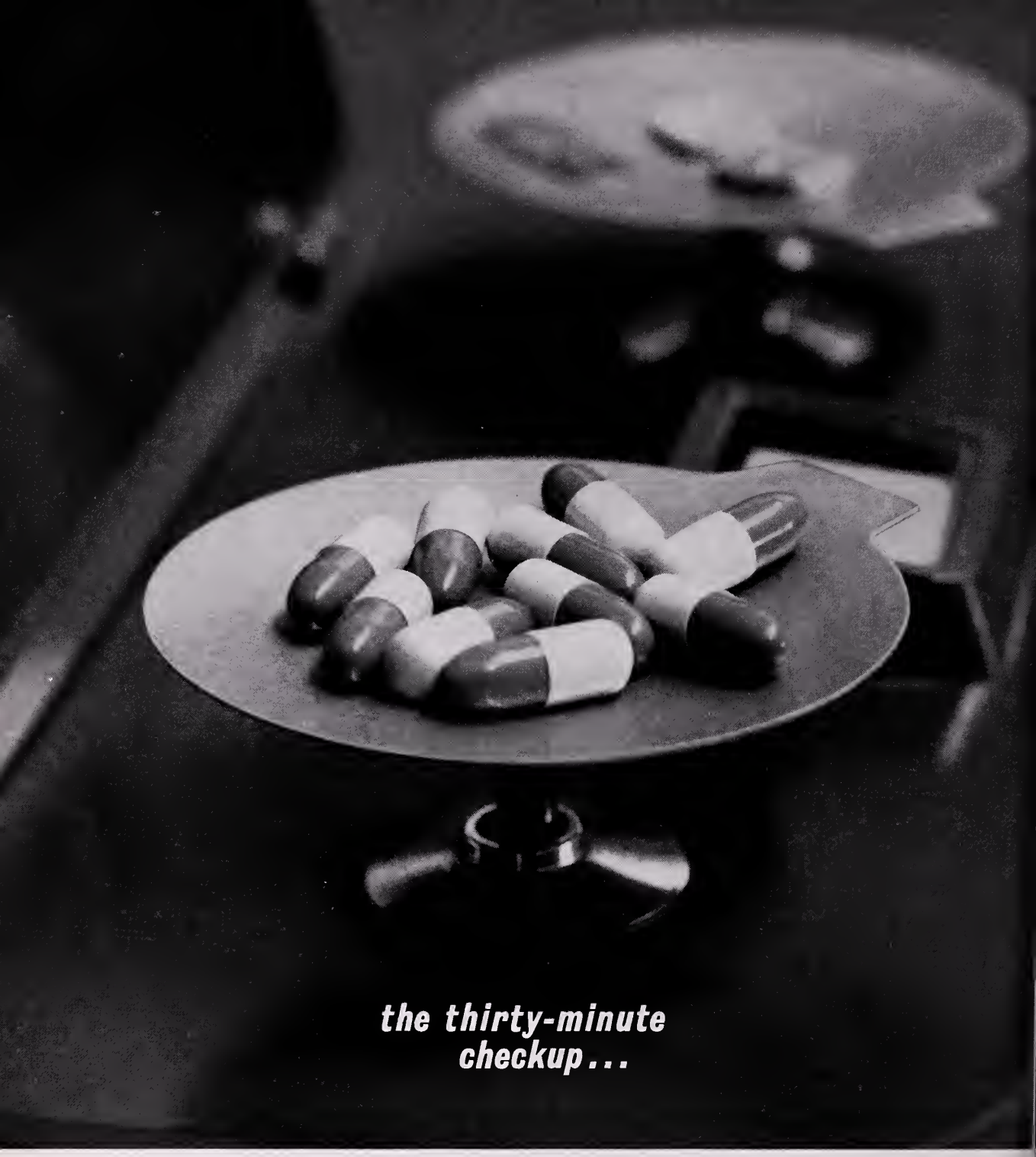


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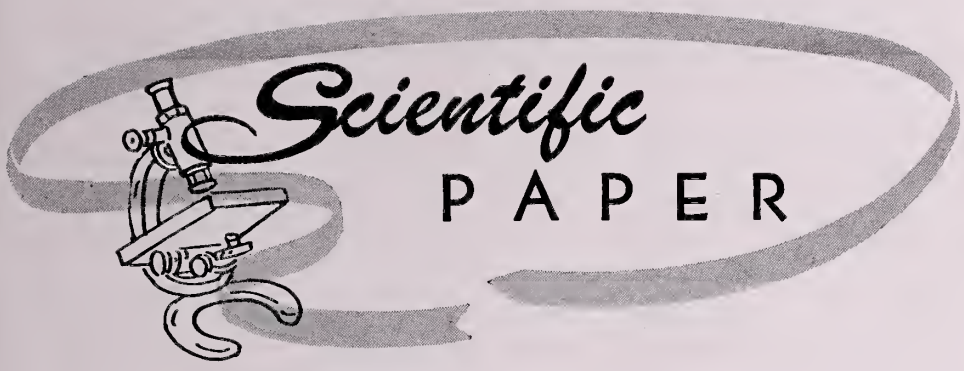


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MULTIPLE MALIGNANT TUMORS

by

John T. Tidd, M.D.*

The occurrence of multiple malignant neoplasms in humans has great theoretical and practical importance, and has been recorded with increasing frequency. Cohan[1] in summarizing the literature noted the occurrence of multiple primary malignancies both during life and at autopsy in 1,259 patients by the end of 1931. Moertel et al.[2] indicated that more than 10,000 cases of multiple primary malignant neoplasms have been documented. In addition they made an analysis of 37,580 patients at the Mayo Clinic who had proven cancers, and they reported that 1,909 of these patients (5.1%) had multiple primary malignancies (Table 1). When multiple cancers of the same tissue were excluded the incidence was 2.8%.

Watson[3] showed that the incidence of true multiple cancers did not differ from the ordinary incidence rate of cancer in a normal population. In a series of 16,626 patients with proven cancer, a second malignant tumor was diagnosed in 1,171 patients, and of these patients, 633 had multiple carcinomas of the same organ. Mider et al.[4] studied 3,996 patients with primary malignant neoplasms of the stomach, uterus, breast, large intestine and hematopoietic system. They found other primary cancers in 179 patients (4.5%) of this series. Warren and Gates[5] performed 2,829 autopsies on cancer victims and discovered 194 instances of multiple primary growths (2.8%). They found that 3.2 years elapsed between the development of the individual neoplasms when this could be measured.

* Director, Tumor Clinic and Registry, Sacred Heart Hospital, Yankton, South Dakota. Associate Professor of Clinical Pathology, Vermillion, South Dakota. This study was supported by a grant from the American Cancer Society, South Dakota Division.

TABLE I
INCIDENCE OF MULTIPLE MALIGNANCIES SUMMARIZED FROM PUBLISHED REPORTS

Author	Total No. of Cases with Primary Tumors	Cases with Multiple Malignant Tumors		Multiple Malignancies			
				Simultaneous Occurrence		Non-Simultaneous Occurrence	
		No.	%	No.	%	No.	%
Warren & Gates[5]	2,829	194	2.8%				
Albrecht[11]	6,189	203	3.3%				
Mider et al.[4]	3,996	179	4.5%				
Watson[3]	16,626	1,171	7.0%				
Farrow[12]	5,576*	262*	3.6%	21	0.4%	181	3.2%
Wallace[13]	3,006	106	7.0%				
Moertel et al.[14]	6,012**	261**	4.3%	157	2.6%	104	1.7%
Robinson et al.[9]	500***	9***	1.8%				
Moertel et al.[10]	1,588***	65***	4.1%				
Malmio[15]	27,712	650	2.3%	180	0.6%	470	1.7%
Moertel et al.[2]	37,580	1,909	5.1%				

*All tumors in the breasts. **All tumors in colon or rectum. 21 patients had additional primary malignant neoplasms in other sites. ***All tumors in the lungs.

Selection of Cases for Study: An analysis of the patients registered in the Tumor Clinic at Sacred Heart Hospital, Yankton, South Dakota, was undertaken in an effort to determine the incidence of multiple primary malignant tumors as well as the pertinent clinical and pathological features. Out of a total of 1,250 patients registered in our Tumor Clinic who had proven malignant disease, it was found that 25 patients (2%) had developed a second malignant neoplasm unrelated to the first. In this group of 25 patients, 13 were females and 12 were males (Table II). The criteria for the selection of these cases of multiple malignancy were those proposed by Warren and Gates[5]: (1) each of the tumors must have a definite picture of malignancy; (2) each must be distinct; and (3) a probability that one was a metastatic lesion from the other must be excluded.

TABLE II
MULTIPLE PRIMARY MALIGNANT NEOPLASMS: AGE OF PATIENTS AT THE TIME OF DIAGNOSIS

	Type of Lesion							
	Simultaneous Occurrence		Non-Simultaneous Occurrence					
			Initial		Second		Third	
	F	M	F	M	F	M	F	M
Average Age	63.7	73.5	64.3	66.4	68	69.6	—	81
Age Range	35-77	68-83	51-77	44-82	54-81	46-84	—	

In considering our cases of multiple malignancy, attention is focused upon the time of occurrence and the sites of occurrence. In some instances the tumors occurred or at least manifested themselves simultaneously whereas in other instances there was a variable interval between the appearance of one tumor and the development of another (Table II). Furthermore, in some patients multiple primary tumors occurred in the same organ or tissues such as multiple skin tumors, whereas in others they appeared in different organs or tissues such as colon and breast.

Case Reports: The 10 cases summarized (Table III) are examples of primary malignant tumors present simultaneously at the time of diagnosis or treatment. Case number 3 is an example of multiple malignancies developing

almost simultaneously in the same organ, whereas in the other cases the tumors occurred in different organs or tissues. Case number 6 is included because of the serious nature of the brain tumor even though it was not considered to be malignant.

TABLE III
SITES OF PRIMARY MALIGNANT TUMORS OCCURRING SIMULTANEOUSLY

Case No.	Age	Sex	Sites of Primary Malignant Neoplasms
1	70	F	Kidney and Urinary Bladder
2	68	M	Stomach and Rectum
3	68	M	Colon (multiple)
4	75	F	Colon and Small Intestine
5	77	F	Colon and Kidney
6	61	F	Breast and Brain
7	64	F	Breast and Uterus
8	83	M	Prostate and Urinary Bladder
9	35	F	Cervix and Appendix
10	75	M	Multiple Myeloma and Colon

1. Mrs. L. L., at age 70, developed sudden severe sharp pain in the left side of her abdomen on 3/27/54. X-ray studies including a pyelogram demonstrated a large tumor in the region of the left kidney. Also a papillary lesion in the left wall of the urinary bladder as well as multiple smaller lesions were visualized by cystoscopy. Biopsy of the lesion revealed transitional cell carcinoma of the urinary bladder. This tumor was treated by fulguration and local resection. A transperitoneal left nephrectomy was performed on 4/2/54; pathological study of the kidney revealed a hypernephroma. She is alive and well 9 years since treatment.

2. Mr. N. S., age 68, complained of epigastric distress, nausea and vomiting. X-ray studies showed a carcinoma in the stomach. Sigmoidoscopy revealed a lesion 10 cm. from the anus, which upon biopsy, proved to be an adenocarcinoma of the rectum confined to the mucosa. A wide resection of an ulcer on the lesser curvature of the stomach was done in September, 1954; this was proven to be a gastric adenocarcinoma. An anterior resection of the recto-sigmoid was done in January 1955. He died in 1958, 3 years and 9 months after the onset of symptoms and treatment. No autopsy was performed.

3. Mr. H. K. had had ulcerative colitis for about 15 years beginning in 1944. In 1959, at age 68, he had had a 30 pound weight loss, and a barium enema showed ulcerative colitis with malignant changes in the midtransverse colon. In November, 1959, a subtotal colectomy was done. In addition to severe ulcerative colitis, pathological examination revealed adenocarcinoma of the colon arising from multiple sites with metastases to the regional lymph nodes. He died 3 weeks postoperatively and 15 years after the onset of the initial symptoms. No autopsy was performed.

4. Mrs. R. J. had had mild epigastric distress for 20 years beginning in 1940 becoming worse a few days before she consulted her physician in May, 1960, at age 75. No abdominal masses were palpable. Proctoscopy was negative to a depth of 21 cm. X-ray studies showed a negative G.I. series; cholelithiasis; Paget's disease of the left pelvic bones; and questionable changes in the cecum and ascending colon. In May, 1960, a right colectomy was performed; the colon contained an adenocarcinoma with metastases in the regional lymph nodes. During surgery a subserosal lesion in the small intestine was biopsied and shown to be a carcinoid tumor of the ileum. She died in November, 1960, approximately 6 months after surgical treatment. No autopsy was performed.

5. Mrs. M. C., at age 77, complained of sudden onset of vaginal bleeding in November, 1959. Previously she had noted a mass in her abdomen accompanied by pain since 1958. Examination showed a markedly enlarged semi-solid left ovary. In November, 1959, a bilateral salpingo-oophorectomy was performed, and pathologic study showed a metastatic papillary, mucinous adenocarcinoma involving the left ovary, omentum and vagina. She died in December, 1959, and autopsy examination revealed a primary adenocarcinoma in the cecum with metastases in the liver, omentum and mesentery. Also discovered was a small hypernephroma of the right kidney.

6. Mrs. D. R. had complained of severe headaches intermittently since 1956, and she had had two masses in the upper outer quadrant of her right breast fixed to the skin since September, 1956. Prior to therapy, her right

axillary lymph nodes were palpable. In September, 1960, at age 61, a simple right mastectomy was performed, and the excised breast showed adenocarcinoma with metastases to the regional lymph nodes. She died 5 days postoperatively, and approximately 4 years after the onset of symptoms. Autopsy showed metastatic carcinoma in the right ribs and thrombosis of the inferior vena cava and femoral veins. Also present was a large meningioma approximately 3.5 cm. in diameter in the left posterior cranial fossa.

7. Mrs. M. P., age 64, had had a large ulcerated mass in the lower outer quadrant of her left breast since February, 1959. This mass was fixed to the skin and chest wall, and was associated with palpable left supraclavicular and axillary lymph nodes. Her chest x-ray was negative. In April, 1959, a simple left mastectomy was performed, and the resected breast contained a poorly differentiated adenocarcinoma. Following surgery she received a total of 8,636 roentgens of x-ray therapy to the operative site and lymph node bearing areas. While convalescing in the hospital she developed severe vaginal bleeding and a curettage revealed adenocarcinoma of the endometrium. In May, 1959, a bilateral salpingo-oophorectomy and total hysterectomy were performed. She is alive approximately 4 years after diagnosis and treatment of her malignancies.

8. Mr. F. T., age 83, had had urinary frequency and hematuria since October, 1959. Cystoscopy revealed a lesion on the right lateral wall of the urinary bladder which had a papillary configuration. In January, 1960, a transurethral resection was performed with local excision of the lesion in the bladder which proved to be a Grade 2 transitional cell carcinoma. The prostatic tissue contained a well differentiated adenocarcinoma. He died in the immediate post-operative period, and autopsy examination revealed residual adenocarcinoma in the prostate; bilateral hydrothorax; ascites; and a large anterior perforation of the urinary bladder.

9. Mrs. J. H., age 35, had had irregular menstruation and vaginal discharge since October, 1957. The cervix was eroded, and a biopsy in March, 1959 showed preinvasive squamous cell carcinoma. A total hysterectomy and appendectomy were performed. The appendix contained a carcinoid tumor. She is alive and well 5 years 9 months after the onset of symptoms, and 4 years after surgical treatment.

10. Mr. E. S., age 75, consulted his physician in March 1962 because of dyspnea for the previous month. Examination showed marked mucous membrane pallor; fine crepitant rales over both lung fields; and a tender palpable mass in the right upper quadrant of his abdomen which was considered to be gallbladder or liver. His lower extremities were markedly edematous with large echymotic pigmented areas. Hgb-4.4 gm%; Hct-13%; and WBC-8,200 with 82% segmented polymorphs, 3% eosinophiles, and 35% lymphocytes. Bone marrow examination was consistent with multiple myeloma. A sigmoidoscopic examination revealed a 2 cm. in diameter polyp 14 cm. from the anus which was treated by local excision and shown to be an in-situ adenocarcinoma. He received urethane for his multiple myeloma. His condition deteriorated progressively during his hospital stay and he died in April, 1962, approximately 2½ months after the onset of his illness and 1½ months after his first treatment. Autopsy examination revealed multiple myeloma involving the bone marrow, spleen, retroperitoneal lymph nodes and kidneys. Multiple adenomatous polyps were present in the colon. Also he had extensive bronchial pneumonia of the left lung superimposed upon severe bilateral pulmonary emphysema; severe arteriosclerotic heart disease; and cholelithiasis.

The 15 cases tabulated in Table IV and summarized here are examples of primary malignant neoplasms with an interval between the appearance of the first primary and the development of a second or third primary malignancy. Cases 19 and 23 are instances of primary malignancies developing in the same organ.

11. Mr. L. J., at age 79, sought medical advice in November, 1957 because of a 50 lb. weight loss and weakness of indefinite duration. Examination revealed anemia and a possible mass in the right side of his abdomen. X-ray studies demonstrated a probable malignancy of the ascending colon near the hepatic flexure. A right colectomy was performed on 11/21/57, and pathological study revealed an adenocarcinoma of the colon with metastases

TABLE IV
MULTIPLE MALIGNANT TUMORS: SITES OF PRIMARY TUMORS AND INTERVAL BETWEEN APPEARANCE

Case Number	Sex	Site of Initial Primary Tumor	Site of Subsequent Primary Tumors	Interval Between Appearance of Tumors
11	M	Colon	Lymphosarcoma	1.5 years
12	F	Uterus	Stomach	6 years
13	F	Skin	Stomach	5 years
14	M	Prostate	Rectum	4.25 years
15	M	Leukemia	Skin	3.5 years
			Prostate	12.5 years
16	M	Rectum	Larynx	2 years
17	F	Breast	Kidney	3.25 years
18	F	Breast	Rectum	3 years
19	F	Breast	Breast	3 years
20	M	Colon	Multiple Myeloma	3 years
21	M	Skin	Stomach	3 years
22	M	Uterus	Bone	4 years
23	M	Skin	Skin	1.5 years
24	M	Lymphosarcoma	Skin	7.5 years
25	F	Breast	Uterus	3.5 years

to the regional lymph nodes. In 1959, 1½ years after treatment of the first malignancy, he consulted his physician because of dull pain in the right lower quadrant, loss of appetite, and constipation. Examination revealed a large mass in the right flank and right lower quadrant of the abdomen. On 5/6/59 the mass was resected, and pathological examination revealed lymphosarcoma (lymphocytic type) involving the large intestine. He died in June, 1960, 2½ years after the first colectomy. He survived 1 year and 1 month after the second procedure. No autopsy was performed.

12. Mrs. J. R., at age 59, consulted her physician in March, 1949 because of postmenopausal bleeding, headache and dizzy spells since July, 1948. She had a slightly enlarged uterus containing one small fibroid. On 3/25/49 a total hysterectomy and bilateral salpingo-oophorectomy were done; an adenocarcinoma of the endometrium was demonstrated. Subsequently in January, 1955, she developed epigastric pain, nausea and vomiting. An enlarged liver was present, and x-ray showed a lesion on the lesser curvature of the stomach which was confirmed by gastroscopy. On 1/10/55 a radical subtotal gastric resection was performed. Pathological study of the stomach revealed an adenocarcinoma. She is alive and well 15 years following her initial symptoms and almost 14¼ years since the hysterectomy for uterine carcinoma. She has survived 8½ years since the gastrectomy for carcinoma of the stomach.

13. Mrs. M. L. developed a lesion on the skin of her left nostril in 1955, biopsy of which showed carcinoma. She was treated by x-ray. In 1959, at age 81, she developed urinary frequency, and examination showed abdominal distention with a large mass in the lower abdomen. X-ray studies indicated a carcinoma of the stomach. At surgery in January, 1960, the lesion was inoperable; there was an extensive obstructing lesion in the body of the stomach with massive pelvic metastases. Biopsy of the omentum showed metastatic adenocarcinoma. She died 6/1/60 surviving 5 years since the treatment of her skin cancer and 9 months since the onset of symptoms associated with the gastric cancer. No autopsy was performed.

14. Mr. P. M. had had prostatism since 1949, and had developed a distinct nodule in the

right lobe of the prostate. A transurethral resection was done in September, 1951 at age 69, and histopathological study revealed adenocarcinoma of the prostate. Subsequently he had a bilateral orchiectomy. In January, 1956, he consulted his physician complaining of severe abdominal pain, nausea and vomiting. Sigmoidoscopy visualized a fungating mass 9 cm. from the anus which was proven to be an adenocarcinoma of the rectum. A combined abdominal-perineal resection was performed. He died in May, 1957, 7 years and 8 months after the onset of symptoms referable to the prostate, and 5 years and 8 months after the transurethral resection. He survived 1½ years after the onset of symptoms and treatment for the carcinoma of the rectum. No autopsy was performed.

15. Mr. L. S., age 69, had had vague symptoms for an indefinite period of time when he sought medical attention in September, 1950. A routine blood count revealed 364,800 leukocytes/mm^3 with 97% lymphocytes compatible with a diagnosis of chronic lymphatic leukemia. Subsequently he developed massive enlargement of his spleen. Between 1951 and 1958 he received 5 courses of x-ray therapy. In 1954 a lesion was excised from his lower lip which had been present since 1946. The lesion was proven to be a squamous cell carcinoma. He was hospitalized in February, 1963 because of burning during and after urination. X-ray studies showed Paget's disease in the pelvic bones; a normal urinary bladder, but questionable diverticula; and a right upper quadrant calcification possibly in the kidney. His prostate was enlarged grade 2, soft, and considered to be non-malignant. A transurethral prostatectomy was done because of bladder neck obstruction; 12 gm. of tissue were resected. Histopathological study revealed adenocarcinoma of the prostate. He has survived 13 years following the diagnosis and initial treatment of his leukemia; 17 years since the tumor developed on his lower lip and 9 years since it was excised; and 6 months following treatment for prostatic carcinoma.

16. Mr. F. H. complained of fullness in his abdomen and dizziness associated with diarrhea since March, 1953. Examination revealed a mass in the rectum which on biopsy proved to be an adenocarcinoma. In September, 1955, at age 69, a combined abdominal-perineal resection was performed. In 1957, he developed difficulty swallowing, intermittent abdominal pain and changes in his voice. Biopsy of the lesion in the larynx showed a well differentiated squamous cell carcinoma. This was treated by means of x-ray therapy. He died in January, 1960, 4 years and 3 months after the combined abdominal-perineal resection, and 1 year and 8 months after the first treatment for the carcinoma of his larynx. No autopsy was performed.

17. Mrs. H. D., at age 51, noted a sore nodule 1 x 2 cm. in the outer portion of her right breast since February, 1953. Biopsy of this lesion showed an infiltrating duct cell type of carcinoma, and in August, 1953, a right radical mastectomy was performed. She was well until 1956 when a mass was discovered in her left flank, and a retrograde pyelogram revealed a tumor in her left kidney. In November, 1956, a left nephrectomy was done, and pathological study showed a renal cell carcinoma. She received 2 courses of x-ray therapy to her left flank beginning in November, 1956; the total dose given was 2,340 roentgens. She died in June, 1957, 4 years and 4 months after the development of the breast mass, and 3 years and 10 months after the right radical mastectomy. She survived about 7 months after the diagnosis and treatment of her kidney tumor. Autopsy examination revealed generalized metastases resembling renal cell carcinoma and involving the lungs, brain, large intestine, mediastinal and retroperitoneal lymph nodes, and the subcutaneous tissues. Also there was a large tumor thrombus occluding the inferior vena cava. There was no evidence of metastases from the mammary cancer.

18. S. M. R., at age 70, noted pain and a mass in the upper portion of her left breast associated with retraction of the skin in December, 1955. Biopsy of the lesion showed a poorly differentiated duct cell type of carcinoma, and a left radical mastectomy was done. In October 1958, she began to have bloody stools. A chest x-ray and barium enema were negative. A mass was visualized by sigmoidoscopy 16 cm. from the anus, which on biopsy showed an adenocarcinoma of the recto-sigmoid. In July, 1959, a left colectomy was performed. She is alive and well 7½ years after the diagnosis and treat-

ment of her breast cancer; 4 years and 8 months since the onset of symptoms from the carcinoma of the colon; and 4 years since her colectomy.

19. Mrs. F. B. had 2 lumps in the upper outer quadrant of her left breast since October, 1949. Her lungs and ribs were negative on x-ray examination. An excision biopsy of these masses showed adenocarcinoma. She was treated in July, 1950, at age 59, by means of a left radical mastectomy. She was well until May, 1953, when she developed a mass in her right breast. A right radical mastectomy was done because of proven carcinoma. She is alive and well 13 years and 9 months after the onset of symptoms and 13 years after the treatment of her first mammary carcinoma, and 10 years after the treatment of carcinoma in the opposite breast.

20. Mr. J. D. had complained of upper abdominal pain since April, 1957. Examination showed an enlarged liver and a mass palpable in the left colon which was confirmed by x-ray studies. In January, 1958, at age 82, a right colectomy was performed because of adenocarcinoma of the hepatic flexure. In December, 1960, a mass was excised from his right orbit which was consistent, microscopically, with a plasma cell myeloma. Later generalized adenopathy appeared and was accompanied by macroglobulemia. He died in January, 1962. The presence of myeloma was confirmed at autopsy. No residual colon cancer or metastases were found. He survived 4 years after his colectomy and 2 years after the diagnosis of multiple myeloma.

21. Mr. F. V., at age 63, had a basal cell type of carcinoma removed from his face in 1957. In 1958 he sustained a stroke and was bed ridden for 2 years. Also he developed a chronic urinary bladder infection 2 months prior to his death in September, 1960. Autopsy examination revealed an unsuspected poorly differentiated adenocarcinoma of his stomach with metastases to his liver and regional lymph nodes. His brain disclosed atrophy of the right cerebral hemisphere. There was no evidence of metastases or recurrence from the skin cancer.

22. Mrs. W. T. developed a mucoid vaginal discharge in November, 1958, at the age of 57. The discharge continued and she consulted her physician in January, 1959. Her cervix was red and eroded, and her uterus was somewhat enlarged and mobile. A uterine curettage revealed adenocarcinoma of the endometrium. Treatment consisted of a total hysterectomy and bilateral salpingo-oophorectomy followed by a course of x-ray therapy to the pelvic area. The total dose of x-ray was 2,880 r. She recovered satisfactorily and was well until the winter of 1963 when she developed pain and swelling in her right hip. Initially it was felt that she had arthritis, but x-ray studies showed evidence of a tumor involving the right ilium. A biopsy of the ilium revealed an osteogenic sarcoma. She was referred to the Mayo Clinic in March, 1963, and a right hemipelvectomy was performed. At present she is in the convalescent phase from the treatment of her bone tumor, and has survived 4½ years following therapy for her uterine cancer.

23. Mr. W. H., age 44, sought medical care in June, 1960 because of a non-healing sore on his lower lip of indefinite duration. Examination revealed no regional lymphadenopathy. An excision biopsy of this lesion was performed and pathological study revealed a moderately well differentiated squamous cell carcinoma of his lip. In January, 1962, he returned to his physician because of a sore on his right lower eyelid which had developed since the previous treatment. An excision biopsy of this lesion was done and histopathological examination revealed a basal cell carcinoma. There has been no recurrence 3 years and 1½ years respectively following surgical treatment.

24. Mr. J. A. was age 56 when he sought medical care in August, 1954 because of difficulty with his bowel movements for three months, unusual fatigue and abdominal pain for two weeks. He had noted epigastric distress after meals and had lost about 5 lbs. during this period. Examination revealed enlarged palpable lymph nodes in both axillae. The liver and spleen were not palpable. X-ray studies revealed a large intra-abdominal mass of undetermined origin. Surgical exploration in August, 1954 revealed an enormous retro-peritoneal mass with many nodes spread throughout the entire mesentery of the small intestine. There were multiple hard, fixed palpable masses up to 5 to 7 cm. in diameter in the peritoneal cavity

most prominent on the left side and in the epigastrium. Biopsy of a mesenteric lymph node revealed a malignant lymphoma. The hemogram showed Hgb-13gm%; RBC-4.4 M; and WBC-8,200 with 76% segmented polymorphs and 24% lymphocytes. He received a series of x-ray treatments to the abdomen amounting to over 1,500 r. Following x-ray therapy he was given Nitrogen mustard. He got along well until August, 1959 when he developed recurrence of the lymphadenopathy and was given 3,800 (r.) to the nodes during a second course of x-ray therapy. In March, 1962 he was hospitalized because of a pleural effusion and axillary lymphadenopathy; 2,200 (r.) were administered to the axillae. Also he had developed a skin lesion on his face which was excised. Pathological study showed a well differentiated squamous cell carcinoma. He has survived 9 years since the original diagnosis and initial treatment of lymphoma, and 1 year since the diagnosis and treatment of his skin tumor.

25. Mrs. J. W. was age 77 in June, 1959 when an 8 x 10 cm. mass in the upper, outer quadrant of her right breast was discovered. It was associated with skin fixation and nipple retraction. She had had gradual loss of appetite, some weight loss and shortness of breath on exertion. Chest and spine x-rays were negative for metastases. She had moderate edema of both feet and ankles. A simple right mastectomy was performed, and pathological study of the resected breast showed papillary duct cell carcinoma. She had an uneventful postoperative course. In November, 1962 she consulted her physician because of bright red bleeding once or twice a day from the vagina for one year. She had lost 15 to 20 lbs. Pelvic examination revealed a mobile uterus approximately 3 times normal size. The adnexae and cervix were not remarkable. The pyelogram was negative, and the barium enema revealed moderate diverticulosis of the sigmoid colon. A uterine curettage was done which revealed adenocarcinoma of the endometrium. Subsequently an abdominal total hysterectomy and bilateral salpingo-oophorectomy were performed. The uterus was found to contain an area of malignancy which had penetrated deep into the myometrium. She has survived 4 years since the initial treatment of her breast cancer and 6 months following treatment of the uterine tumor.

Discussion: The development of multiple primary malignancies in humans supports the idea that the stimuli which produce cancer operate systemically rather than locally, and that these common carcinogenic stimuli can operate over a period of many years i.e. case No. 15. In those instances in which the tumors appeared simultaneously, it is apparent that the stimuli were quite potent whereas in those patients in whom the tumors appeared at appreciable intervals it would seem that the stimuli were less potent although not necessarily less harmful in their action.

The occurrence of multiple malignancies also supports the concept of the multicentric origin of tumors rather than a unicentric origin as proposed by Cohnheim and others. Auerbach et al.[6, 7] in their studies of lung cancer have shown the simultaneous presence of areas of epithelial atypia, squamous cell metaplasia, carcinoma in-situ and/or early invasive carcinoma in the bronchial epithelium of patients dying from overt lung cancer. Studies of uterine cervical cancer provide additional evidence for the multicentric origin of tumors.

Moreover the development of multiple malignancies indicates that the occurrence of a primary cancer does not produce immunity to the development of a second primary malignancy.[2, 8] Similarly the risk of developing a second cancer is not increased by the presence of a previous primary malignant neoplasm with the possible exception of cancers in the breast and colon.[4]

Although the incidence of these cases is low, the number of patients generating second, third or even more primary malignant neoplasms is sufficiently great so that the possibility must be kept constantly in mind. Furthermore, it is reasonable to assume that the incidence of multiple malignant tumors is actually greater than reported in this study of patients registered in the Tumor Clinic at Sacred Heart Hospital or in the other studies to which we have referred in this article. A patient may develop a second primary malignant tumor which is diagnosed and treated in a different hospital in another city by different physicians than managed

the patient's first primary cancer without this knowledge being available to the registry. Another source of error which tends to decrease the apparent incidence of multiple malignancies is the possibility that a second primary cancer is not recognized and is thought to be metastatic disease or some other disorder. In addition autopsy examinations not infrequently disclose asymptomatic primary malignancies unrecognized during life; obviously these lesions would not be discovered if autopsies were not performed thus lowering the apparent incidence.

It is evident that the physician should be aware of the distinct possibility that a given cancer patient may develop or harbor a second primary malignant tumor unrelated to the original tumor, and he must be alert not to confuse the patient's symptomatology and signs with possible metastatic disease arising from the original primary. Frequently if the condition is correctly interpreted by means of exploration, biopsy and pathological study, it is possible to offer these patients beneficial treatment which prolongs their lives and prevents a premature death which might otherwise occur because of the mistaken belief that the physician is dealing with a metastatic lesion rather than a second primary cancer.[9, 10]

Summary: (1) A brief review of the literature is presented. (2) Twenty-five additional previously unreported cases of multiple primary cancers are discussed. (3) Several theoretical concepts are mentioned that are supported by the occurrence of multiple primary malignancies. (4) The practical importance of being alert to the occurrence of multiple malignancies is emphasized.

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SURGERY FOR HEARING LOSS DUE TO OTOSCLEROSIS

by

James R. Tabor, M.D.

Denver, Colorado

Hearing loss due to otosclerosis is very gradual and otherwise asymptomatic.

The patient will first notice that he misses words if the speaker is at some distance. He will state, "I cannot hear the speaker in a meeting or if someone talks with a soft voice in a quiet room." He may relate, "If the surroundings are noisy requiring people to speak up, I hear better than my friends." Commonly this patient may complain that he cannot hear television or family members while chewing noisy foods such as potato chips. In these individuals bone-conduction is better than air-conducted sound, and noises from chewing (heard by bone-conduction) unduly interfere with the air-conducted conversation. Otosclerosis is familial and frequently family members have this type of hearing loss. As the hearing loss progresses many people purchase hearing aids to obtain the necessary amplification to carry on in business or social situations. Many have successfully worn a bone-conduction type of hearing aid in the past.

Otosclerosis causes a progressive hearing loss which is gradual. It commonly starts during the second or third decade of life and is simply a mechanical problem. The otosclerotic bone or focus originates from the edge of the oval window and represents an attempt to repair a tiny congenital defect in this region. This abnormal bone grows into the footplate of the stapes causing its fixation by varying degrees. This, of course, mechanically blocks the sound as it attempts to enter the inner ear through the stapes. The sur-

gical problem is clear. Because surgery for otosclerosis has attained a high degree of success, many people with this impairment may be helped.

In contrast to the people with otosclerosis, the individuals with sensori-neural hearing loss complain, "I can hear your voice but I cannot understand." They state, "When it is noisy or if more than one person is talking, I hardly get a word." Because a mixture of hearing losses may occur in one person, some of these people may have otosclerosis in addition to the sensori-neural loss. Some of these people, therefore, may be helped by stapes surgery. The conductive part of these mixed hearing losses is diagnosed by tuning fork and audiometric tests.

The physical examination is usually normal. The tympanic membrane appears healthy but the tuning fork tests are abnormal. First, a 1024 cycle per second tuning fork placed on the forehead will lateralize to be best heard in the poorer ear. Secondly, the fork will be heard better on the mastoid by bone than by air (Rinne negative). This finding is virtually a pathognomonic sign of significant conductive hearing loss. The audiometric tests in the soundproof room show the exact extent of the hearing loss and the exact chance for surgical success. At this time current surgical techniques yield approximately 90% chance for restoration of hearing to the "nerve" or bone-conduction level. This usually means a practical hearing level for the patient.

Once the diagnosis is made the first surgical step is to turn back the drum to expose the region of the stapes (Fig. 1). The second step is to remove the superstructure of the stapes so that the fixed footplate remains in place (Fig. 2). The footplate is partially removed by the use of small picks and hooks. (Fig. 3). Since the fluid of the inner ear is exposed it is important that antibiotics are used during the post-operative period to eliminate possible labyrinthitis.[1] At times it is necessary to use a drill on a footplate greatly thickened by otosclerotic bone. Although many types of prosthetics are used to replace the stapes, either wire or tubing is most common. After positioning Gelfoam over the footplate a Teflon tube may be placed between the incus

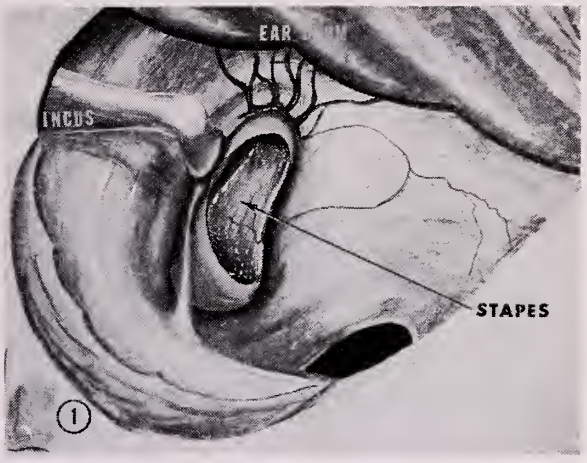


Fig. 1: Surgeon's view of the stapes after turning the tympanic membrane forward.

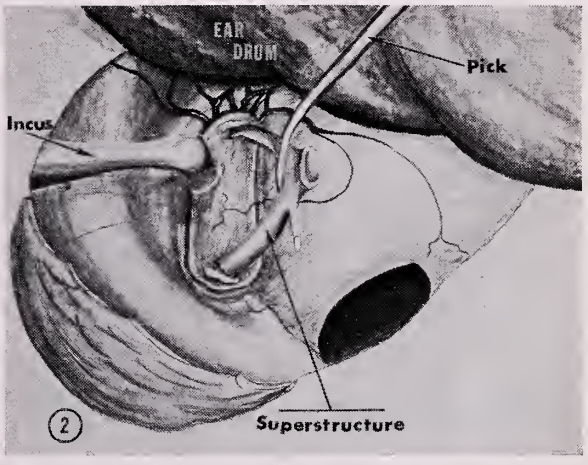


Fig. 2: Superstructure of the stapes being removed with a pick.

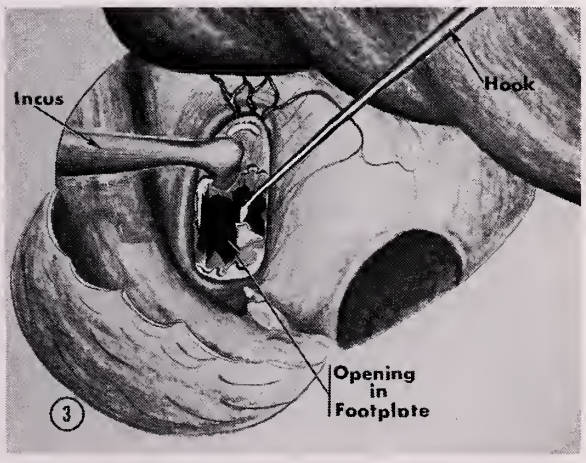


Fig. 3: Fenestra being made in the footplate of the stapes with a hook.

and the Gelfoam (Fig. 4).[2] On the other hand a stainless steel wire may be placed between the incus and Gelfoam[3] (Fig. 5) or a vein graft[4] may be used with the wire in place of the Gelfoam.

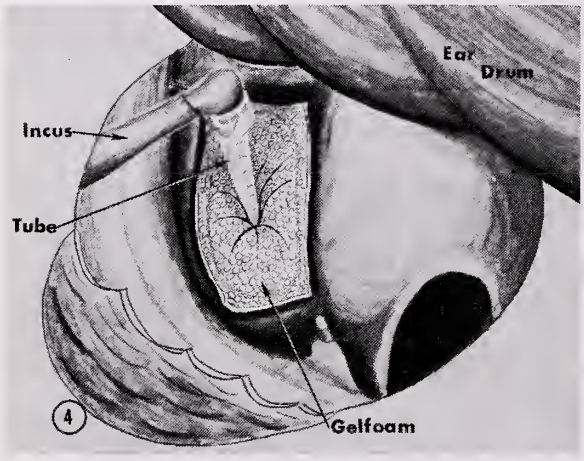


Fig. 4: Gelfoam covers fenestra in footplate and the tube is placed between the Gelfoam and the incus.

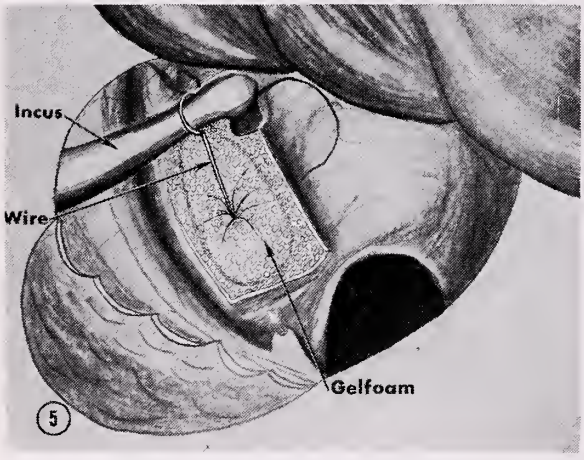


Fig. 5: Gelfoam is placed over the fenestra in the footplate and wire is placed between the Gelfoam and the incus.

SUMMARY

Diagnosis of otosclerosis may be made by tuning fork tests. A high percentage of success now results from surgical techniques for this hearing impairment.

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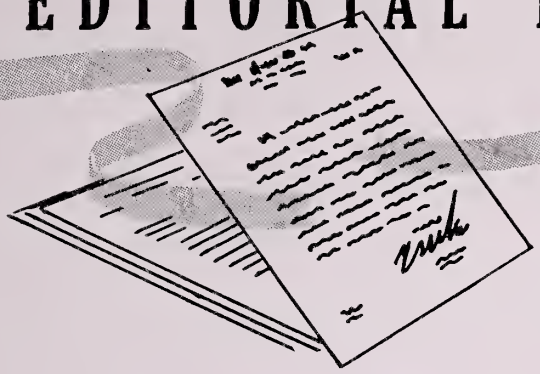
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EDITORIAL PAGE



DOCTORS REPLY TO ACCREDITATION EDITORIAL.

(EDITOR'S NOTE: The following is being run as an editorial although it was presented to the Journal as a letter to the editor. The author of the previous editorial is a member of the Editorial Committee, but through an oversight his initials were not placed at the end of the editorial. Ordinarily, the initials of the editorialist should appear, unless they are written by staff people who would not present material of a controversial nature. The editorial was written by John B. Gregg, M.D., an Otolaryngologist in Sioux Falls, and was signed when submitted.)

A recent editorial in this Journal[1] asks for opinions on the obviously controversial subject of hospital accreditation. Several arguments, as they were advanced in that article, should not remain unopposed. It is assumed that the author is not a member of the Editorial Board and that his personal views do not reflect the opinion of the Journal and, for that matter, of the State Medical Association. In order to avoid misunderstanding, it would have been better to publish this article as a "Letter to the Editor," stating clearly that this is the opinion of the author only.

It is undisputed that the Joint Commission on Accreditation exerts, at least for some hospitals and their staffs, an uncomfortable pressure. However, a short look at the history of this Commission will show that not outsiders, but physicians, have created this body to establish minimum standards for hospitals. That these minimum standards were increased in time is natural, and they will be higher in the future. Medicine has progressed in the last 50 years; and, what was advanced then is outdated today.

In 1918 the American College of Surgeons drew up the "Minimum Standards," which set forth the requirements for the care of the sick. Besides these, the American Hospital Association and also the American Medical Association independently maintained a listing of approved hospitals. These initial efforts were pooled in 1952 at which time the Joint Commission on Accreditation of Hospitals was created. This Commission consists now of the following four member organizations:

1. American College of Surgeons,
2. American Medical Association,
3. American Hospital Association, and the
4. American College of Physicians.

The aim of hospital standardization is the improvement of patient care.[2] The Board of Governors consists of a clear majority of physicians, as one can easily see, and neither surgeons nor the hospital administrators have a decisive vote.

The "Standards for Hospital Accreditation,"[3] so far as complete medical records and medical staff organization is concerned, outlines clearly what generally is recognized as good medical and hospital practice. To fulfill these requirements, which can be adjusted locally, should not be too difficult, even for smaller and rural hospitals. Since the standards are well defined, no staff should be in doubt as to whether its own policies are in accord with national minimum requirements for accreditation.

At present there is no necessity for the hospitals in South Dakota to obtain accreditation. In fact, only 16 out of 73 nongovernmental hospitals, admittedly the larger ones, have voluntarily sought such recognition. In the East, insurance companies have already indirectly pressured the hospitals into compliance by higher liability insurance rates and lower insurance benefits. But, would it be so terrible, if some of the smaller hospitals improved the standard of their care, even in rural areas?

In reading the editorial, one wonders why the author is against a system of selfcontrol and selfpolicing through a combination of hospital committees, such as Medical Audit-, Surgical-, Credentials-, Record-, Tissue-, Fracture-, and other committees.

If one's work cannot pass the judgment of one's peers, one must look for the reasons. The hospital staff should not tolerate poor performance of any person connected with it, professional and nonprofessional alike. Since, in near future, the professional stature of any physician will be enhanced by the fact that he is on the staff of an accredited hospital, he should do something to earn such privilege.

Let us take up the arguments of the author point by point as to why the proposals for accreditation of hospitals should not be carried out:

1. Medical records reflect the level of medicine practiced in that hospital. If one has worked on a Record Committee and has seen how scanty some examinations and findings are recorded, even if it is assumed that they are done, one wonders really how the attending physician has arrived at his diagnosis. If the writer has his records as well written as his article in the Journal, he will have no difficulties with his Record Committee. And, if the medical records of his hospital are in that top shape, then it should matter little to him how much weight is given to good records in the judgment of the Commission. His hospital can easily comply with that particular demand.

2. Delineation of the Staff privileges is the most frequently misunderstood of the intended proposals of the Commission. In the larger communities — and most of the accredited hospitals are situated here — the greater part of the medical profession already practices specialty medicine, with or without certification. A brief look into the Directory of Physicians, etc., licensed in South Dakota,[4] — or for that matter the Yellow Pages — underscores this point. (Since Sioux Falls is taken for an example, the figures for that city are: Out of 92 physicians, 19 listed themselves as general practitioners and 11 as general practitioners with a part time specialty. This is even less than the National average.[5]) It is obvious that most of the physicians have already recognized that they cannot follow the progress of medicine as a whole, and therefore have limited themselves to a specialty field in their office practice. However, in the hospitals, where more severely ill patients and difficult problems are treated, these physicians, according to the author, suddenly want to treat everything and everybody.

If one has his patient's welfare in mind, it should be easy to transfer the self-limitation from the office practice to the hospital. It is not detrimental to a physician's professional standing to consult a colleague, who is more experienced in a special field, on a severely ill patient, if this patient does not happen to fall into the usual line of medicine practiced by the attending physician. This would not hinder, but improve the care any physician gives to his patients. Every one of us knows colleagues who have practiced Internal Medicine for many years and often do not know where the operating or the delivery room in the hospital is located. These colleagues do not need and do not want major surgical or obstetrical privileges, but are entitled under the present system to do gastrectomies. If one does such complicated procedures very infrequently, one should not be considered properly qualified and practiced under presently accepted standards. One step on the way is the self-limitation, which is already exercised by the Board specialists. The next one would be that physicians, who have limited themselves, make it part of the hospital records. Emergency care would not be governed by such regulations. The few true general practitioners could be assembled in a Department of General Practice and given all privileges they may have enjoyed until that time and have performed adequately in the opinion of the Medical Staff, according to training, experience and judgment.

If the Credentials Committees of the hospitals in cooperation with the Medical Audit-, Surgical Privileges-, Tissue- and Fracture-Committees have shown cause that privileges of a certain staff member can be enlarged or should be limited, this must be decided by vote in a meeting of the entire staff.

3. The question as to what constitutes major and minor surgery can be easily decided. If the author would have acquainted himself with the literature[6] of the last 25 years on this subject, he would find there is little to discuss. A very simple solution, for example, appears to be that major surgery constitutes every procedure which endangers the life of the patient. This includes such things as 1. general anesthesia, 2. entering of body cavities, 3. cancer, and 4. removal of organs.

General anesthesia in itself already carries a considerable risk for the life of the patient. (The corrected mortality for inhalation-anesthesia is about 1 death in 2143 anesthesias.[7])

The famous "grandfather - clause" is frequently brought up to protect privileges acquired by custom. Age in itself is not always an equivalent for training, experience and judgment. And if a human life is at stake the possibility of mistakes from whatever cause should be kept down as much as possible.

It is assumed that the author of the editorial himself is young enough not to invoke this clause for himself in lieu of other qualifications.

5. The question — why it should be necessary to introduce such regulations into South Dakota now, can easily be answered: Even our State should move ahead to improve, strengthen and tighten the organization and selfcontrol in our hospitals in order to improve patient care.

If our selfpolicing is not successful, with or without Joint Commission on Accreditation, we might be forced under the control of non-medical outside forces, the Hospital Governing Board, for example, as it has happened not only in Europe, but also in our northern neighbor, Canada. Free practice of medicine will be wiped out then, and not, as said in the article, by the proposals of the Joint Commission.

That the limitations of Staff privileges and other measures, as complete medical records etc., will improve the care of our patients appears obvious from this viewpoint. The increased protection against malpractice suits may be a desirable side effect. It is never the primary purpose. Complete histories and physical examinations of patients on admission to the hospital along with adequate work-ups and frequent consultation enhances the patient's respect for the physician; promotes more adequate medical and surgical management; produces better results for all concerned; and, makes compliance with the "Minimum Standards" automatic. This, in turn, will rehabilitate the public respect for our profession and our hospitals.

The interested reader of the Journal finally, might question the wisdom of printing a second editorial about the advisability of verbal prescriptions to the patient directly in the same issue.[8] We no longer live in an era of the horse-and-buggy and no telephones where such a practice might have been customary. It would seem extremely doubtful that South Dakota physicians give such drug information to patients, with the possible exception of instruction for simple "over the counter" medications. If the second article was necessary, then it is high time that we **do** wake up and **do** something about the subjects discussed in both editorials in order not to find ourselves on a level of medicine hardly accepted in countries which now send their physicians to us to further their education.

C. R. Stoltz, M.D.
E. H. Heinrichs, M.D.

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A LETTER TO THE EDITOR

The Editor
South Dakota Journal of Medicine
711 North Lake Avenue
Sioux Falls, South Dakota

Dear Sir:

The undersigned, author of the Editorial under discussion in this issue of the Journal, and a member of the Editorial Board of the Journal, thanks the discussors for their comments. The manuscript went to the EDITOR of the Journal with a signed letter of submittal but the author's signature was lost later, in transit. The author never has and never will submit an anonymous piece for publication. Ideas presented in the Editorial were the words of one, but the thoughts of several individuals who were involved in the recent hospital inspections. It was not the **purpose** of periodic inspections of hospitals which caused consternation but the criteria for evaluation and the ambiguity of the concepts of what constitutes acceptability of a hospital. By virtue of the fact that it has initiated rebuttal, this Editorial has achieved its intended purpose. It is to be hoped that future Editorials may stimulate thought, discussion and comment from members of the South Dakota State Medical Association.

John B. Gregg, M.D.

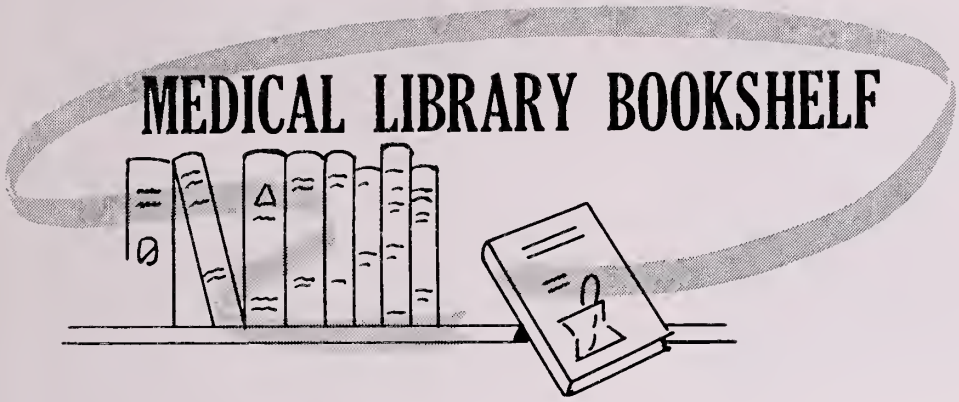
COUNCIL RECOMMENDATION

Recently the Council of the State Medical Association took action to recommend that physicians in prescribing, instruct the pharmacist to put the trade name of the drug on the label, unless there was some medical reason for not so doing. The basis for the action by the Council is the fact that in our nation's transient population, we have a great number of people who get a prescription in one place, run into an emergency situation in another and the doctor in the new location is unable to determine what medication had been prescribed previously. The recommendation for using the drug name on the label has been accepted in many other states and eventually will be common procedure throughout the country.



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DIABETES

Journal-Lancet, now in the 94th year of publication, is a journal that serves the medical profession of Minnesota, North Dakota, South Dakota and Montana.

The September, 1963 number is a special issue on Diabetes Mellitus with outstanding authorities contributing articles. Since diabetes is one of the most common afflictions of man, and is increasing at an alarming rate, this collection of practical and authoritative articles should be of exceptional interest to the general practitioner. A bound reprint of the entire symposium is available by writing to Dr. E. A. Haunz, Department of Medicine, Grand Forks, North Dakota.

The first article in **Journal-Lancet** is written by Dr. Thomas P. Sharkey and is entitled "Diabetes Detection in General Practice." Dr. Sharkey is President of the American Diabetes Association and Assistant Clinical Professor of Medicine at Ohio State University. This includes information about urine testing, blood sugar determinations and other diagnostic techniques. The statement is made that the glucose tolerance test, done carefully under standard conditions is still the most reliable method for diagnosis of early diabetes in routine practice.

The second article by Dr. J. S. Danowski, of the University of Pittsburgh School of Medicine and Vice-president of the American Diabetes Association, "The Mode of Action of Insulin" is a summary for clinically oriented physicians of the effects of insulin upon carbohydrates, protein and fat metabolism in certain tissues.

The third article, "Insulin in the Treatment of Diabetes" by Dr. Alexander Marble of the Joslin Clinic, Boston, is an excellent article for the selection of type, dose, and time of administration of insulin.

Dr. Leo P. Krall, also a member of the Joslin Clinic, Boston, contributed the fourth article, "The Acute Treatment of Diabetes Acidosis." Emergencies including ketoacidosis and coma, that complicate the course of diabetes mellitus, need accurate diagnosis and rapid initiation of treatment. One valuable table gives a diabetic acidosis and coma treatment schedule, adapted from the Joslin Clinic.

Dr. Rachmiel Levine and Dr. Morton Smith, both of the Department of Medicine of New York Medical College in the fifth article, "Oral Hypoglycemic Agents" review briefly the oral insulin substitutes from 1878 to date and discuss at some length the mechanism of action of sulfonylureas and biguanides, and clinical use.

"Juvenile Diabetes" by Dr. Priscilla White of the Joslin Clinic, Boston, the sixth article, contains a valuable table showing duration in hours, buffer, pH, and action as well as type and appearance of available types of insulin. A sample diet for the control of diabetes in the juvenile patient is also included.

The last article by Dr. Blair Holcomb, Clinical Professor of Medicine and Dr. John W. Partridge, Clinical Associate of Medicine



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of the University of Oregon Medical School, "Pregnancy Complicating Diabetes" includes diagnosis, treatment, and classification of diabetic mothers. A need for careful attention to the obstetrical, as well as the medical details of management, is emphasized.

Excellent, up to date lists of references are given at the end of each of these articles.

A new book in our Medical Library on diabetes is **The Pancreas in Human and Experimental Diabetes** by Dr. Sydney S. Lazarus, Chief of Pathology and Assistant Director of the Isaac Albert Research Institute of the Jewish Chronic Disease Hospital, and Dr. Bruno W. Volk, Director of this same Hospital, Grune and Stratton, 1962. This book includes a Historical Review; the Normal Pancreas; Experimental Diabetes; The Human Pancreas in Diabetes; Islets in Infants of Diabetic Mothers and The Hyperglycemic Sulfonylureas and the Pancreas.

Esther Howard
Medical Librarian

THE ILLUSION OF ABSOLUTE DRUG SAFETY

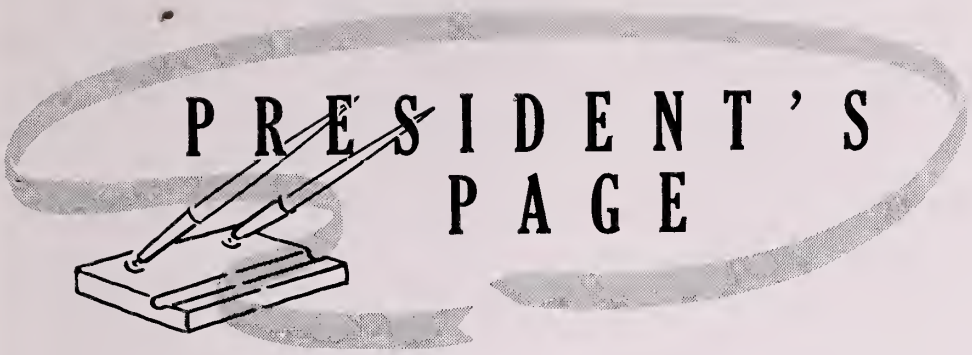
We must consider drug safety, not as an afterthought to tragedy, but as an integral element of our scientific advance. We must be carefully safe, but we can never be absolutely safe. There is some risk attendant on the acquisition of new knowledge and its application. To me, the future calls for a greater emphasis on the ways and means whereby the results of our enormous investment in health research can be applied for the betterment of mankind. The counterparts of insulin, pamaquine, digitalis, or even common salt in babies' formulas can be dangerous if improperly used. — Lowell T. Coggeshall, M.D., to Division of Medical Sciences, National Academy of Sciences — National Research Council, April 9, 1963.

J. O. COOK, M.D.

J. O. Cook, M.D., pioneer physician of the Fairfax-Bonesteel area, passed away Wednesday, October 16th.

Dr. Cook practiced at Fairfax from 1900 until 1946, when he moved to Bonesteel.

He is survived by his wife, and a sister.



Dear Fellow Members:

Dr. Wessman, Dr. Whitney and myself, had the pleasure of attending the Venereal Disease Seminar in Cleveland, Ohio, the last week in October. It was a joint meeting of physicians, laboratory directors and United States Public Health field workers. Although the program was not primarily arranged for physicians, there were some detailed points of interest to us that were noted. One of the points of concern was that syphilis is on the increase instead of on the decrease as we should expect it to be. There were many reasons forwarded for this and from what I could gather no one explained it satisfactorily. One of the points made was that since physicians have now taken over the task of treating syphilis and the government-sponsored, government-staffed, Quick-treatment Centers have been closed an increased incidence has occurred somehow. As was pointed out by physician members of the various panels we practicing physicians must assume our responsibilities in this matter. These workers did not feel that we were not treating syphilis satisfactorily, but rather that we might not be treating it in the epidemiological fashion in which it should be treated. As I sat there and listened to the speakers, I was convinced that they had a point. The busy practicing physician can not take time to elicit a careful contact history with all its ramifications. I also was aware that the group was pressing an obvious answer — that is "let the trained epidemiologist PHS worker elicit this contact history for us." To me this took the matter out of our hands and placed it in a non-medical person's hand. However, I was impressed by the sincerity of this group of young people and their dedication to this task. One physician stated that these same workers would not be given the trust of the physicians in this matter, but "that they would have to earn this trust." Certainly, this seems to be the answer and I feel that these young men will earn this trust and will become a part of our medical team — nurses, technicians and social workers. I feel that with the antibiotics, the improved methods of testing, and finally the epidemiological approach that we, indeed, should be able to eradicate syphilis.

Some of the other points of interest to physicians would be the new serological testing methods which have become so complex that one almost needs a new alphabet to designate them. One point discussed was that of a new gonorrhea culture method for females which would yield something like an 86% accuracy rate instead of the gram staining method we are now using which yields about 2% accuracy rate. One of the other points of interest for physicians was that of a new test for penicillin sensitivity which will be reprinted, with permission of its author, in one of the future issues of our South Dakota Medical Journal.

Dr. Wessman, Dr. Whitney and myself plan to confer with Dr. Van Heuvelen in the near future, survey our program in South Dakota, and bring our conference results to the attention of our Committee on Public Health of our Medical Association. From the meeting surveys, I was pleased to note that South Dakota rated quite highly in the program of diagnosis, treatment, and prevention. I am sure that we must not relax our vigilance, but rather must give the problem constant attention and, with this, I feel that we can eradicate syphilis in the State of South Dakota.

Fraternally,

Robert H. Hayes, M.D.

COUNCIL MEETING MINUTES
SUNDAY, OCTOBER 6, 1963
THE INN, HURON, SOUTH DAKOTA

The meeting was called to order by E. J. Perry, M.D., Chairman of the Council at 1:00 p.m. Present for roll call were Drs. E. J. Perry, R. H. Hayes, A. P. Reding, P. Hohm, Magni Davidson, J. J. Stransky, M. C. Tank, L. C. Askwig, Fred Leigh, Preston Brogdon, E. T. Lietzke, T. H. Sattler, Harold Lowe, and Robert Giebink.

Dr. Brogdon moved that the reading of the minutes of the previous meeting be dispensed with inasmuch as they have been published in the South Dakota Journal of Medicine. The motion was seconded by Dr. Hohm and carried.

The Council discussed the resolution proposed by the National Society for Medical Research as follows:

I. A statement of philosophy that makes clear the humanitarian nature of scientific study of animals. Here is such a statement in the form of a resolution.

WHEREAS careful studies involving animals have been and are responsible for nearly all progress in animal husbandry and veterinary medicine; and

WHEREAS it is a historic fact that similar studies of animals have provided to scientists working on human disease problems essential knowledge about the basic mechanisms of the living body and the fundamental nature of health and disease; and

WHEREAS in accordance with the ethics of medical science and the laws of the United States, the safety of every new drug must be investigated first in laboratory animals; and

WHEREAS new surgical procedures and other medical treatments are brought to high levels of safety and effectiveness through experiments on lower animals before being applied to human patients; and

WHEREAS dangerous dusts, fumes, chemicals and many other environmental health hazards are explored by animal tests rather than by endangering human lives; and

WHEREAS knowledge of the effects of radiation and the means to combat such effects in man depends largely on study of irradiated animals; and

WHEREAS study of living creatures is fundamental in the training of students in the life sciences and the health professions; and

WHEREAS it is the established policy of the United States Government to conduct and support research and tests on animals for the safety and welfare of the citizens of the United States and of peoples throughout the world; and

WHEREAS the precision of animal studies demands appropriate care of the animals to minimize extraneous factors that produce misleading results; and

WHEREAS man has an ethical responsibility to animals he uses for his benefit; and

WHEREAS advancements in laboratory animal care will serve the welfare of man as well as animals; Now, therefore, be it

Resolved by the Senate and the House of Representatives of the United States of America in Congress Assembled

Sec. 1. It is the sense of Congress that animals studied under programs of the Federal Government or supported by Federal Grants or contracts shall receive every practicable consideration; that they shall be kindly treated, fed and watered properly and their surroundings shall be maintained in a sanitary condition.

Sec. 2. It shall be the policy of Federal departments and agencies that conduct or support studies requiring the use of animals to take constructive action to advance the care of laboratory animals through:

a. Research in laboratory animal health, care and use.
b. Training in laboratory animal health, care and use.
c. Dissemination of information on laboratory animal health, care and use.
d. Provision of adequate facilities for laboratory animal health, care and use.

II. The assignment of authority and responsibility to Federal government agencies for the advancement of laboratory animal care. Following are (1) a general delegation of authority and (2) two samples of specific delegations of authority.

GENERAL AUTHORITY OF FEDERAL AGENCIES

Sec. 3. In carrying out the policy expressed in sections 1 and 2 of the Joint Resolution of Congress (above) all departments and agencies of the United States Government that conduct or make grants or contracts for studies utilizing live animals shall be authorized to conduct and support programs of research, training, information and building for laboratory animal health, care and utilization which are consistent with their mission and requirements.

SPECIFIC AUTHORITY OF INDIVIDUAL AGENCIES

AUTHORITY OF SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE

Sec. 4. Part A of Sec. 3, Title III of the Public Health Service Act (42 U.S.C. Chap. 6A) is amended by adding immediately after Section 309 the following new section:

"CARE AND TREATMENT OF LABORATORY ANIMALS"

"Sec. 310. The Surgeon General is authorized to conduct and support research and training relating to adequate care, treatment and utilization of laboratory animals. In carrying out the foregoing the Surgeon General is authorized to:

a. Conduct in-the-service research and training relating to adequate care, treatment and utilization of animals for research, testing and training purposes;
b. Collect and make available, through publications and other appropriate means, information relating to such adequate care, treatment and utilization;
c. Make grants-in-aid to universities, hospitals, laboratories, and to individuals for such research projects and/or programs or training projects and programs on laboratory animal care and utilization as are recommended by any national advisory council established by or pursuant to the Public Health Service Act.
d. Make grants-in-aid to appropriate public and non-profit institutions engaged in research in the sciences related to health for the support of professional supervision of animal care programs in such institutions."

AUTHORITY OF THE SECRETARY OF AGRICULTURE

Sec. 5. The Secretary of Agriculture is authorized to conduct and support research and training relating to health, treatment, and use of laboratory animals. In carrying out this responsibility the Secretary is authorized to:

a. Conduct in-the-service research and training relating to health, treatment, and use of laboratory animals for research, testing and training purposes in connection with programs or projects undertaken or financed by the Department of Agriculture;

b. Collect and make available to the public through publications and other appropriate means, information relating to health, treatment and use of laboratory animals;
c. Make grants-in-aid to universities, hospitals, laboratories, and individuals for such research projects and programs and training projects and programs relating to laboratory animal health, treatment, and use as said Secretary considers will be most beneficial to projects or programs undertaken or financed by the Department of Agriculture.
d. Make grants-in-aid to appropriate public or non-profit institutions engaged in research in the sciences related to animal health for the support of professional supervision of laboratory animal care programs in such institutions.

III. Provide a means for the coordination and potentiation of Federal government programs for the advancement of laboratory animal care. Following is a plan utilizing the facilities of the President's Science Advisory Committee.

NATIONAL COUNCIL ON LABORATORY ANIMAL CARE

Sec. 7. The Chairman of the President's Science Advisory Committee shall establish a council dealing with laboratory animal care. Such Council shall facilitate the coordination of efforts of various Federal and non-federal agencies to provide adequate care, treatment and utilization of laboratory animals. It is not intended that the Council shall set dogmatic standards that could limit development of better methods of animal husbandry; rather that the Council shall work for optimum progress in the science and art of laboratory animal care.

The Council shall consist of a designated representative of the President's Science Advisory Committee who shall be chairman, a representative appointed by the Secretary of Health, Education and Welfare, a representative appointed by the Secretary of Agriculture, a representative appointed by the Secretary of Defense, a representative appointed by the chairman of the Atomic Energy Commission, a representative appointed by the Director of the National Science Foundation, a representative appointed by the Administrator of the Veterans Administration, a representative appointed by the Director of the National Aeronautics and Space Administration, a representative appointed by the Administrator of the Federal Aviation Agency and six members appointed without regard to civil-service laws by the Chairman of the President's Science Advisory Committee. The six appointed members shall be leaders in the field of laboratory animal care and use.

Dr. Brogdon moved that the Council endorse the resolution as submitted. The motion was seconded by Dr. Tank and carried.

The request for endorsement of the accreditation program proposed by the Nursing Home Association was considered. Dr. Sattler moved that the Council go on record as endorsing the proposed accreditation program and that a physician be appointed to the Advisory Committee. The motion was seconded by Dr. Reding and carried.

Implementation of the Self Employed Individual Tax Retirement Act was discussed. Dr. Hohm moved that any action on implementation be tabled. The motion was seconded by Dr. Davidson and carried.

The Council then considered the Report of the Committee on Legislation.

Item No. 1. Proposal by South Dakota Bar Association to amend law concerning physicians confidential relations privilege. The Committee on Legislation recommends to the Council that the State Medical Association endorse the proposal of the Bar Association.

Dr. Stransky moved the acceptance of this portion of the report. The motion was seconded by Dr. Lietzke and carried.

Item No. 2. Recommendation of the Reference Committee that legislation be introduced at next session of Legislature providing for appointment of Industrial Commissioner for a six year term by Governor. The Committee on Legislation recommends to the Council that steps be taken by the Association's legal advisers to determine the activities necessary to accomplish this and that the Medical Association endorse the proposal to provide for continuity in the office of the Industrial Commissioner.

Dr. Davidson moved that the Council accept this portion of the report. The motion was seconded by Dr. Tank and carried.

Item No. 3. Proposal to increase annual registration fee for Board of Medical Examiners to $5.00 per year. The Committee on Legislation recommends to the Council that the State Medical Association endorse a $5.00 annual registration fee for all licentiates of the South Dakota Board.

Dr. Hohm moved that the Council adopt this portion of the report. The motion was seconded by Dr. Giebink and carried.

Item No. 4. Proposed bill to set up a graduated system of charges for the care of the mentally ill at Yankton State Hospital. The Committee on Legislation recommends to the Council that endorsement be given to this proposed law.

Dr. Davidson moved that this portion of the report be accepted. The motion was seconded by Dr. Sattler and carried.

Item No. 5. The Committee on Legislation recommends that the Council pass a resolution asking the American Medical Association to clarify its position on Federal grants.

WHEREAS, The American Medical Association has taken specific stands on many legislative issues involving the use of Federal Funds to finance medical services, staffing and construction; and

WHEREAS, These stands have not always been consistent in support or in opposition to the provision and use of such Federal Funds; therefore,

BE IT RESOLVED, That the South Dakota State Medical Association requests the American Medical Association to review its entire policy regarding the use of Federal Funds for medical services, staffing and construction, bearing in mind the inadvisability in general of the use of such Federal Funds, and to issue a report on this matter at the 1964 Clinical Session; and further,

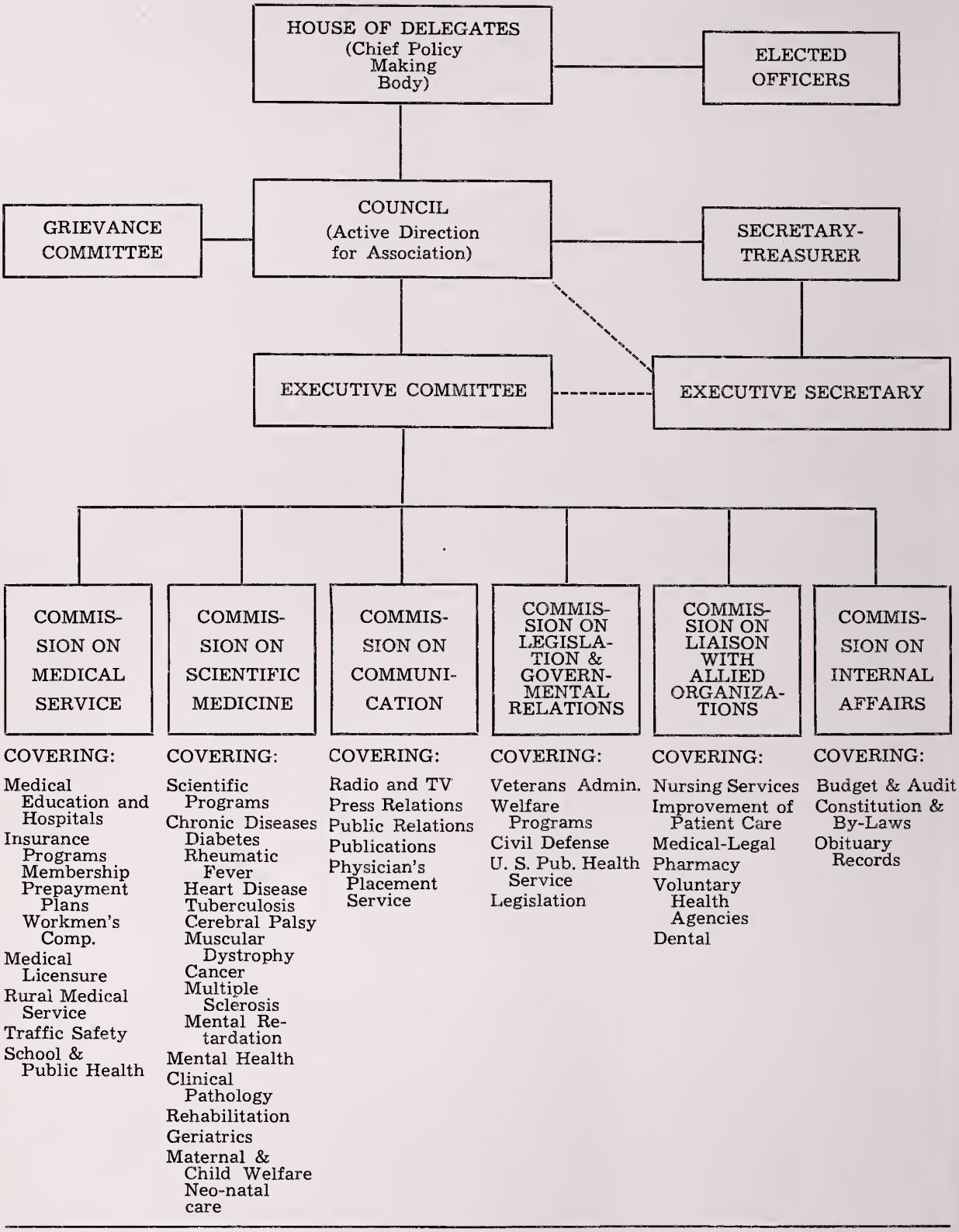
BE IT RESOLVED, That a copy of this resolution be distributed to the component member associations of the American Medical Association.

Dr. Sattler moved the adoption of this portion of the report. The motion was seconded by Dr. Tank and carried.

Item No. 6. The Committee discussed legislation on the "child beating syndrome." A Model law will be secured and studied by the Committee and a definite recommendation presented at the January Council meeting.

Dr. Hohm moved the adoption of this portion of the report. The motion was seconded by Dr. Hayes and carried.

Item No. 7. The Committee also went on record as approving further efforts by physicians in



South Dakota to defeat legislation to provide medical care through Social Security and asked that the Council reiterate its previous stand on this subject.

Dr. Brogdon moved the adoption of this portion of the report. The motion was seconded by Dr. Tank and carried.

The Council studied the report of the Committee on Revision of Committee Structure.

Dr. Stransky moved that the Council accept the recommendations of the Committee and submit the necessary changes in the Bylaws to the House of

Delegates at the next annual meeting. The motion was seconded by Dr. Brogdon and carried.

The Council considered the matter of fees for ophthalmologists under the OAA program. Dr. William Kilpatrick of Huron appeared before the Council to discuss the situation. It is the feeling of the ophthalmologists in the State that opticians should collect their fees directly from the Welfare Department when the ophthalmologist does not do his own dispensing. Dr. Giebink moved that the matter be referred to the Fee Advisory Committee for study and recommendation. The motion was seconded by Dr. Stransky. Dr. Brogdon moved to amend the motion to indicate that the Council approves the recommendation that the Department of Welfare should pay the charges of the retail dispensers directly when the ophthalmologist does not dispense. Dr. Sattler seconded the amendment to the motion. The amendment to the motion was carried and the original motion as amended was carried.

A report on the activities of the State Department of Health in the Federal Vaccination Assistance Program was made. Dr. Sattler moved that the Council go on record as opposing the program and that the State Department of Health be so notified; that the president and secretary of each District Medical Society be notified of the action of the Council. The motion was seconded by Dr. Leigh and carried.

Dr. Perry read a letter from the co-chairmen of the South Dakota Political Action Committee, giving notice of their resignation. No action was taken on this matter, but the Councilors were asked to inform their Districts of the resignations.

The names of Drs. T. F. O'Toole of the 9th District; J. D. Alway of the 1st District; and M. W. Pangburn of the 5th District were submitted for Honorary Life Memberships in the South Dakota State Medical Association. Dr. Tank moved that these physicians be elected to Honorary Life Memberships. The motion was seconded by Dr. Hayes and carried.

The Council considered the recommendation from the Medical and Chirurgical Faculty of the State of Maryland concerning the fees for multiple surgeries under the Medicare program. Dr. Brogdon moved that the Council of the South Dakota State Medical Association not endorse the Maryland proposal. The motion was seconded by Dr. Hayes. Dr. Stransky moved that the motion be amended to indicate that material from Maryland should be given to the Fee Advisory Committee for informational purposes. Dr. Hohm seconded the amendment to the motion. The amendment to the motion was carried and the motion as amended was carried.

It was determined that the original Fee Advisory Committee should be utilized again, with the vacancies to be filled by the president of the Association as necessary.

The matter of scientific exhibits at annual meetings was discussed by the Council. Dr. Hohm moved that the Council should not make any definite percentage rule on scientific exhibits at this time and that the registration fee at annual meetings be increased from $5.00 to $10.00 to help cover the cost of the scientific exhibits. The motion was seconded by Dr. Stransky and carried.

Dr. Hayes discussed the appointment of Dr. G. S. Owens of Rapid City to replace Dr. Lyle Hare on the Advisory Committee to Selective Service. Dr. Giebink moved that the Council approve such an appointment. The motion was seconded by Dr. Tank and carried.

The Council discussed the matter of labeling all prescription drugs as suggested by the Yankton District Medical Society, inasmuch as they felt it was a desirable principle to follow.

LABELING OF PRESCRIPTION DRUGS*

Should the patient know what drug he is taking? Should the name of the drug be written on the label where anyone can see it? Do patients know too much about their illness and its treatment? These are some of the questions physicians are asking themselves today.

Time was when doctors told their patients nothing and the patients seemed to want it that way. But the rising level of education among the American people, their great interest in matters of sickness and health, and the transformation of the "doctor-priest" to "doctor-scientist" have all contributed to the patient's expectation that his illness will be explained to him and that he will be told about the proposed treatment and what to expect from it. Doctors have encouraged this trend by writing medical columns in newspapers and magazines and by speaking to lay groups, as well as by bringing more nonphysicians into the "medical-care team" as salaried or volunteer workers or as contributors to funds raised for medical care and medical research.

A small but significant part of this trend is the growing practice of indicating the name of the drug on the label of the box or bottle of medicine that the patient takes home from the pharmacy. It is obvious that this cannot and should not be done in every case. Some drugs should remain nameless at times — the opiates and the barbiturates, for instance.

There are also patients who are better off if they do not know what they are taking. These include some who might become psychologically dependent on the drug and some who try to "outguess the doctor" and make the decisions themselves. Other patients still regard medicines as "magical potions" and may be deprived of a valuable psychological crutch if they are disillusioned.

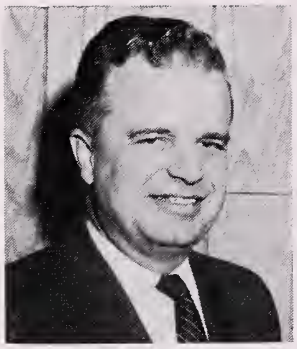
A frequent objection to labeling the prescription package is the fear that this will encourage the patient to decide for himself when to start and stop taking the drug, or tempt him to "doctor" his friends and neighbors. But the physician's explanation regarding the purpose of a prescribed drug and what may be expected from it, together with the public's growing awareness of the powerful effects of drugs — both beneficial and harmful — should help to discourage such practices.

In most cases the physician will want to tell the patient the name of the drug, and to have its name and strength indicated on the label. The ready availability of this information is obviously of great help when the patient has symptoms, which may be untoward reactions, or which may result from too high a dosage. It is also invaluable when the patient changes doctors, moves to another locality, or contacts the doctor when his records are not at hand. The name of the drug and its strength on the label may save precious minutes and spell the difference between life and death in cases of attempted suicide, accidental overdosage, or accidental poisoning of children. Furthermore, naming the drug, or at least indicating its purpose on the label, helps to prevent mixups between two or more drugs that are being taken concurrently, or between drugs being taken by different members of the family.

Because there are so many advantages to labeling drugs, because there must be exceptions to this practice, and because only the patient's physician can and should decide when the name should be on the package, the Council on Drugs has passed the following resolution:

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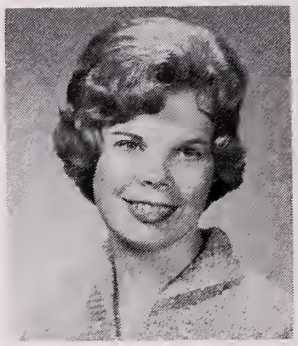
* Copied from the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, July 27, 1963, Page 316.



John C. Foster
Executive Secretary



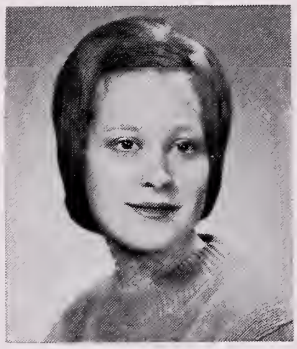
Patty Butler
Administrative Asst.



Judee Schlosser
Assistant Editor



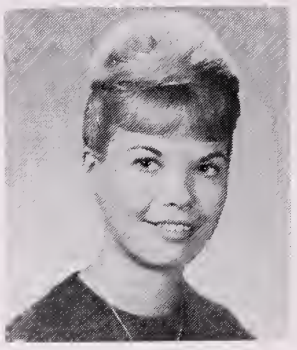
Judy Burkman
OAA Clerk



Sharen Brown
Claims Clerk

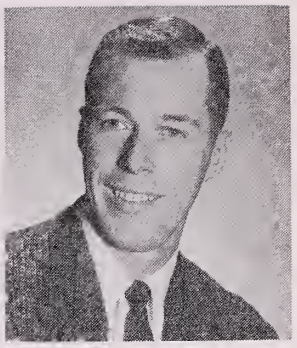


Helen Heisler
Claims Clerk

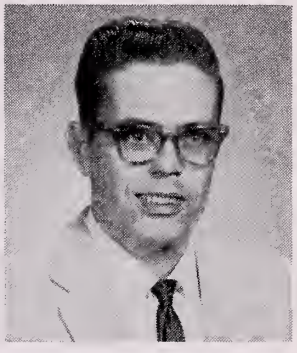


Mary Heisler
Claims Clerk





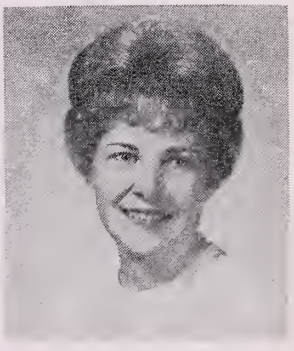
Richard C. Erickson
Asst. Exec. Director



Robert Green
Office Manager

Gayle Naessig
Blue Shield Secretary

Pat Briggs
IBM Operator



Kathy Gerloff
Claims Clerk



Eve Sylvester
Claims Clerk



Elaine Konrad
Claims Clerk



Judy Elbert
Claims Clerk

> The Council resolves that it favors labeling of prescriptions as a general practice, and, furthermore, it is recommended that prescription pads contain boxes for a "yes" or "no" on whether to label; if these boxes are not filled in by the physician, the prescription will be labeled.

Such labeling of prescription drugs, whenever practicable, is one more step toward bringing about better understanding between patient and physician, and improving relationships between the pharmacists and the physician and between physicians and the public.

Dr. Giebink moved that the Council accept the resolution as presented and inform the District Societies to that effect. The motion was seconded by Dr. Sattler and carried.

The Council considered the subject of accepting osteopaths in the Group Plan of the State Medical Association for Blue Cross and Blue Shield. Dr. Sattler moved that the Medical Association group not accept any additional osteopaths in the group and that the Osteopathic Association be approached by Blue Shield and Blue Cross to set up their own group plan on the same basis as the Medical Association group. The motion was seconded by Dr. Tank and carried.

The Council considered the proposal presented to the Medical Association by the State Department of Health, as to whether or not the Medical Association would be willing to co-sponsor with the State Department of Health regional meetings on staph and other infections in hospitals. If the Medical Association is willing to co-sponsor the meetings, the State Department of Health is prepared to bring in top flight men in the field of epidemiology. It was indicated that the proposal originated in a meeting of the South Dakota Joint Commission to Improve the Care of the Patient. Dr. Sattler moved that the information should be furnished to the various District Medical Societies and that the Council accept the request to co-sponsor the meetings and urge the District Societies to participate in the program; also that the information be furnished the Program Committee of the annual meeting for their consideration. The motion was seconded by Dr. Hayes and carried.

The Council discussed the grand prize for the annual meeting inasmuch as Dr. Peik does not care to take the prize he won. Dr. Sattler moved that Dr. Peik be awarded a good set of golf clubs. The motion was seconded by Dr. Tank and carried.

Dr. Sattler discussed the matter of funds available for indigent adults who are in need of cardiac surgery. Dr. Sattler moved that the problem be referred to the Committee on Legislation and requested the Committee to formulate a plan of action to present to the Legislature next year, aimed at placing this problem in the hands of the Rehabilitation Department where funds can be made available for this purpose. The motion was seconded by Dr. Tank and carried.

Dr. Hayes spoke on the program of the Mentally Retarded Association people regarding PKU testing, using a new method. Dr. Hayes moved that the Council recommend to the District Societies that we endorse the idea as a pilot study and a worthwhile experiment and that it should be looked into thoroughly; that the legislation proposed by the group regarding PKU be referred to the Committee on Legislation for study and action this year; and that the State Medical Association work closely with the committee of the Mentally Retarded Association on this problem. The motion was seconded by Dr. Leigh and carried.

The meeting adjourned at 4:30 P.M.

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

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Pop's Proverb

Free advice is like calories — if you take it all you'll be overweight.

Among the names of doctors to be associated with Project Hope in the near future we find **C. A. Stern, M.D.,** Obstetrician-Gynecologist from Sioux Falls. The information was furnished in the October issue of **Hope/-News.**

* * *

Don R. Salmon, M.D., previously associated with Drs. Quinn and Brzica in Sioux Falls, has left to begin private practice at 504 South Cleveland in Sioux Falls.

* * *

The Fourth edition of **Side Effects of Drugs,** an up-to-date review of unwanted effects of drugs as reported in the medical literature of the world during the period 1960-1962, is now available. The publisher is Excerpta Medica Foundation, 119-123 Herengracht, Amsterdam, The Netherlands; price $7.50.

A very successful Stroke Rehabilitation Seminar was held in Aberdeen on Saturday, September 21st. Those taking part in the program included **Dr. W. R. Taylor,** Sister M. Alacoque, and **Dr. W. F. Steinman** of Aberdeen; Nancy Best of Sioux Falls and **Dr. Sylvester Clifford** of Vermillion.

* * *

G. J. Bloemendaal, M.D., Ipswich physician and surgeon, was recently honored by that community for his 35 years of service. An interpretation of a "This Is Your Life" series of events included friends and relatives from South Dakota and other states.

* * *

Three South Dakotans were recently inducted into the Fellows of the American College of Surgeons. The three are **Edward G. Huppler, M.D.,** of Watertown; **H. L. Ahrlin, M.D.,** of Rapid City; and **C. L. Behrens, M.D.,** also of Rapid City.

LEAD INDUSTRIES GROUP COMBATS UNFAIR PUBLICITY

A recent statement given in newspapers cited the following statistic: "70% of deaths due to poison in the preschool age group are caused by lead poison." This allegation has been investigated by the Lead Industries Association, Inc. and found to be in error. Citing the United States Department of Health, Education and Welfare Public Health Service, Division of Accident Prevention report dated December, 1962, their findings were as follows.

In 1960 (the last year recorded), 445 deaths due to accidental poisoning involving children under 5 years of age are recorded. Seventy-eight of these, or **17.5%,** are attributed to lead and its compounds. Over the ten-year period covered in this report, 1951 through 1960, the percentage figure stands at 12.5%.

R. E. OGBORN, M.D. RECEIVES STITT AWARD

Richard E. Ogborn, M.D., Chief of the Radioisotope Service at the V.A. Hospital in Omaha, Nebraska, is the recipient of the Stitt Award for outstanding achievement in medical research. The award, consisting of a plaque and a $500 honorarium, was established in 1954 as a memorial to the late Rear Admiral Edward Rhodes Stitt, a former surgeon general of the U. S. Navy. The award is sponsored by Pfizer Laboratories.

Doctor Ogborn received his B.A., B.S. and M.S. degrees from the University of South Dakota, and his M.D. degree from the University of Louisville Medical School. He is a brother of **Robert J. Ogborn, M.D.,** of Sioux Falls.

* * *

NO KING-ANDERSON THIS YEAR

On Tuesday, October 22, House Speaker John McCormack (D) Mass., at the President's weekly breakfast conference of Democratic leaders, stated that medical aid for the aged financed through Social Security is dead for this session of Congress . . . Representative Wilbur Mills (D) Ark., Chairman of the House Ways and Means Committee, made a similar pronouncement when he appeared before the House Rules Committee on September 18.

At the time of writing, prospects for hearings were still in sight, but obviously no action would be taken.

MEDICAL EDUCATION 200 YEARS OLD IN USA

The University of Pennsylvania recently announced plans for a 1965 celebration of the Bicentennial of Medical Education in the United States. The observance will mark the 200th anniversary of the founding of the University's School of Medicine, the first medical school established in this country.

The announcement was made by President Gaylord P. Harnwell, following action taken by the Trustees at their fall meeting on the campus.

The University of Pennsylvania School of Medicine was founded in 1765, when Trustees of the University — then known as the College of Philadelphia—appointed the first medical professors in the Colonies and offered the first academic medical school where students could enroll and earn their medical degrees.

Official opening of the Bicentennial will take place at the beginning of the academic year next fall. A University Convocation, September 19, 1964, will strike the keynote, paying tribute to medical advances in the nation during "the first two hundred years" and heralding the progress anticipated in the century ahead.

AMA-FDA CONFERENCE GETS COMPETITION

The American Medical Association and the Food and Drug Administration sponsored their second national conference on medical quackery on October 24-26.

Not to be outdone, an organization calling itself the National Health Federation scheduled its "first national congress on health monopoly" — same dates, also in Washington. The federation claims a large national membership, including a substantial number of producers of "health foods."

One of the major discussions at the Federation meeting had to do with what it considered to be collusions between AMA and FDA on the "Krebiozen" matter. According to the Federation's announcement "The object of this conference is to bring together major and minor American groups who are really concerned about preserving **freedom of choice** on matters of health. This congress will explore charges that an unholy alliance exists between the American Medical Association and the Food and Drug Administration. We shall investigate collusive actions by these organizations that, if left uncorrected and uncontested, would completely destroy originality and competition in the healing arts."

AMA-FDA said they were concerned with "educating the public about quack devices and treatments used to bilk gullible persons of an estimated $1 billion a year."

Life magazine, in its issue of November 1, carried an article that shows an unusual court decision which it considers unique in the annals of this subject.



Pictured above is the centerpiece used at the reception honoring Mrs. C. R. Stoltz, President of the Woman's Auxiliary to the American Medical Association. The pheasant motif was carried out in order to emphasize her being from South Dakota.

CONGRATULATIONS TO DOCTOR JAMES N. BERBOS AND THE MEMBERS OF THE ST. LUKES HOSPITAL STAFF

The Editorial Staff of the South Dakota Journal of Medicine and the members of the State Medical Association salute Doctor James N. Berbos and his associates for a job well done. Their professional competence, skill and fortitude in the face of a highly unusual situation should command the admiration of all physicians; their selflessness without thought of personal gain should demonstrate to all that altruism has not departed from medicine.

Doctor Berbos's actions and skill should prove a feather in the cap of all who proudly call themselves General Practitioners. His stalwart actions and philosophy will do much to advance the concept of the well trained, competent family doctor. Although few physicians will ever have the opportunity to experience any comparable situation to test their skills, the fact that this miracle occurred in a small, relatively isolated community but the problems which it occasioned were handled with as much precision as might be expected in a large, expensive medical center, demonstrates to the medical community and to the community at large that the General Practitioner and the local hospital are not anachronisms. By such actions as these shall men who practice medicine be known.

Both Doctor Berbos and the members of the hospital staff are to be commended for the diplomatic and admirable way in which the total situation was handled. Terrific pressures for self-aggrandizement and monetary gain are put upon individuals in such situations of notoriety by the press and others who may have ulterior motives for their own self-enrichment. The ability to resist these pressures, to maintain the self-composure, humility and decorum emblazoned in the Hippocratic Oath during periods of stress is a severe test of the mettle of the man. Those in Aberdeen who participated in the medical portion of this event have come through with flying colors. They are all to be congratulated. —J. B. Gregg, M.D.



The five gentlemen above are members of the Board of Directors of the State Medical Journal Advertising Bureau, Inc. From left to right: Frank B. Ramsey, M.D., Chairman; Joseph I. Waring, M.D.; Perry R. Ayres, M.D.; Mr. John C. Foster; and Edgar Woody, Jr., M.D. The picture was taken at the Journal Conference in Chicago, October 21 and 22.



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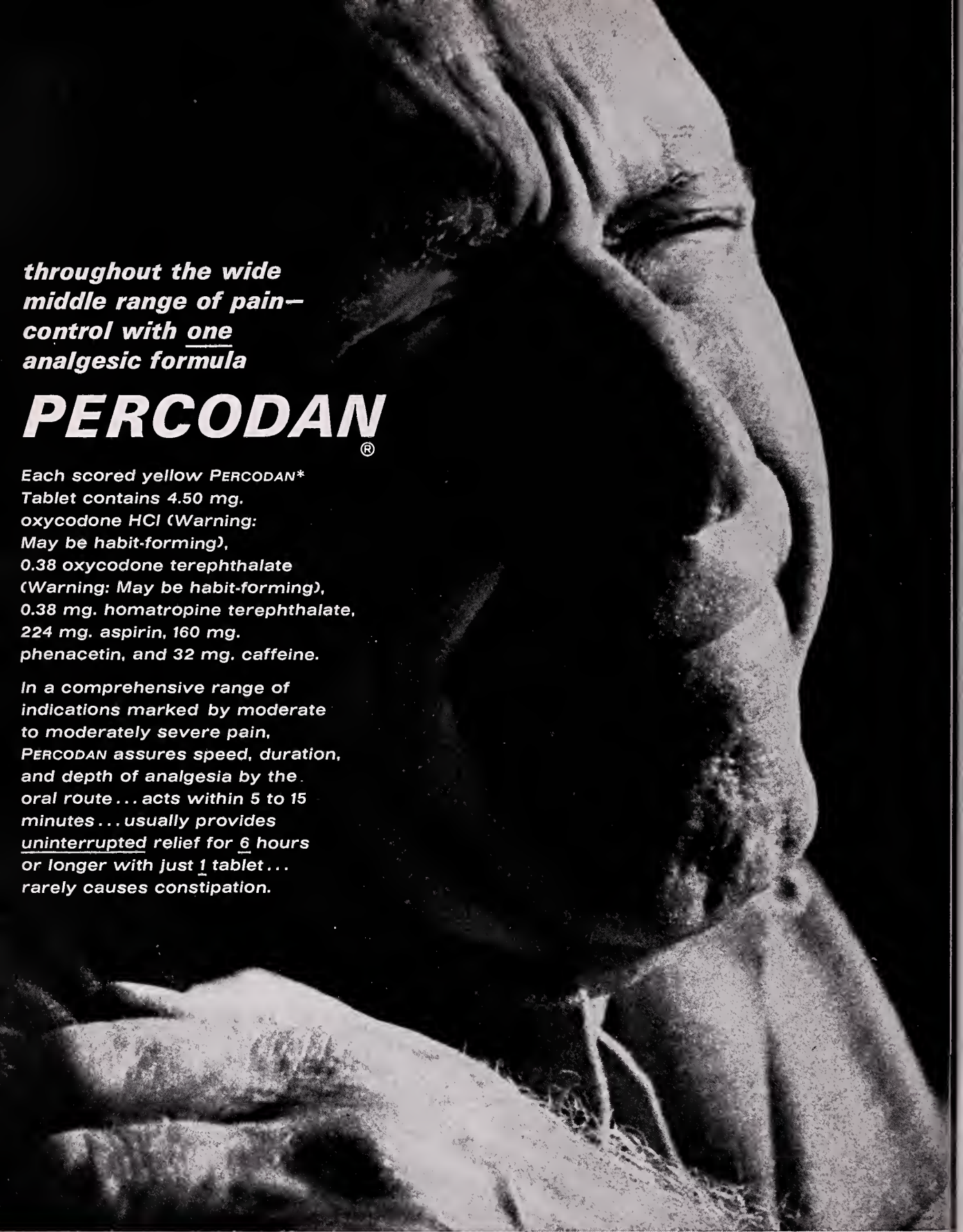
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100's of Invalid needs

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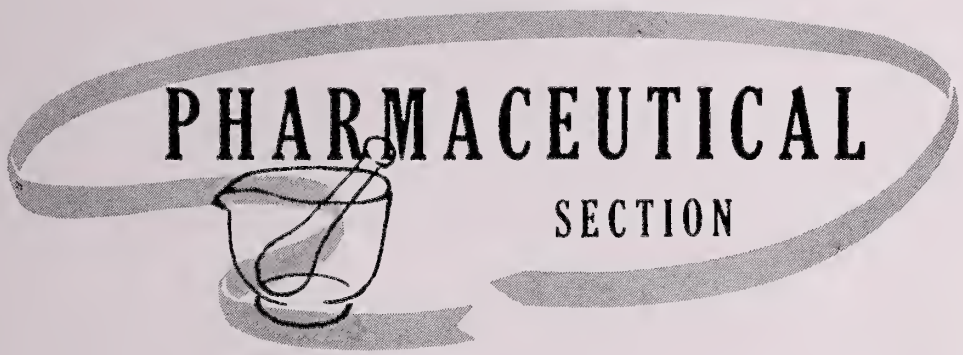
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Each scored yellow PERCODAN* *Tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.*

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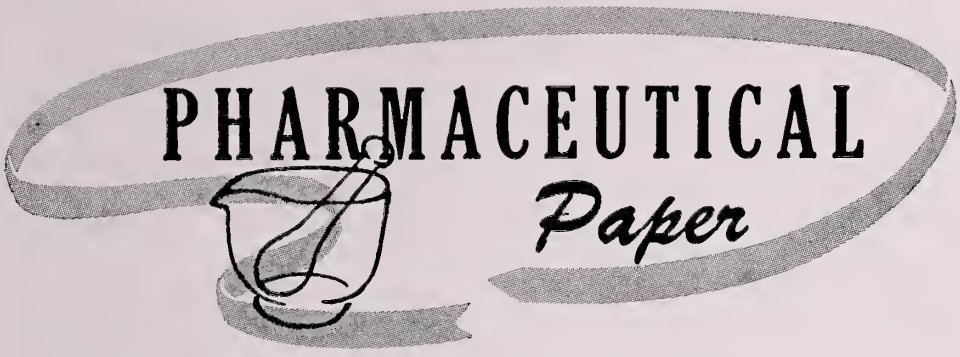
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A PHARMACY OWNER SPEAKS*

by
Robert J. Gillespie**
St. Joseph, Michigan

Fellow pharmacists, ladies and gentlemen. I am very pleased to be with you today and to bring you the greetings and best wishes of the officers and members of the American Pharmaceutical Association. I am especially pleased that you asked me to be one of your speakers. Your invitation continues the exchange of official visits that APhA began last spring when President Frank Lobraico addressed a general session of the APhA annual meeting in Miami Beach. We were all impressed with Frank's recommendations for teamwork and unity in achieving solutions to pharmacy's many problems.

Frank Lobraico and I have many things in common. We have both been presidents this year of national pharmacy organizations; we are both members of the APhA and the NARD; and we are both owners of community pharmacies.

As owners, most of us here today are active, long-time members of NARD, a pharmacy organization of, for and by owners. As pharmacists, most of us are active and long-time members of APhA, the national professional society of, for and by pharmacists. That APhA and NARD share such a large membership shows the dedication of pharmacists to their national and specialty organizations.

APhA membership, as you well know, includes researchers, teachers, editors, government officials, executives and other specialists. We are just as proud of these pharmacists, who make up about ten percent of APhA membership, as we are of the practitioners — employer and employee pharmacists alike — who make up ninety percent of our membership. So long as all pharmacists in the United States can belong to the APhA and to their state and local pharmaceutical associations, there will be no need for a union organization of employed pharmacists.

You and I, in our common effort as community pharmacy owners, share many problems and satisfactions. I feel that my life as a pharmacy owner in St. Joseph, Michigan, is little different from Frank Lobraico's in Indianapolis, Indiana, or from your own in your town. Nor is it much different from that of my fellow APhA officers — First Vice President John Stadnik, Second Vice President Mike Harris, House of Delegates Chairman Calvin Berger, and the other community pharmacy owners guiding APhA.

We owners all face an endless flow of paperwork; long hours of management activities; and local, state and national regulations and laws, which we must uphold, in addition to our personal professional responsibilities. We all draw the same wonderful satisfaction from serving the health needs of people we know and love. We all strive to provide the

*A Speech Delivered Before the Convention of the National Association of Retail Druggists, Chicago, Illinois, October 10, 1963.

**President, American Pharmaceutical Association.

environment in which our pharmacists can practice pharmacy with us as professional associates. And, we all seek to advance the public health through pharmacy, for the public health, after all, is our only reason for being.

As Frank Lobraico said in Miami Beach, there is much that teamwork and unity can accomplish. We have seen examples of it this year. There is the APhA-NARD effort to resolve the physician-ownership problem. Out of this effort has come the Commission on Medicine and Pharmacy and the National Congress to be held next spring. There has been the support given by APhA to NARD in its role as leader of the drive to secure Quality Stabilization. This APhA support has included testimony submitted on House of Representatives Bill 3669, which was introduced by pharmacy's good friend, Congressman Oren Harris. APhA continuously urges support and enactment of H.R. 3669.

Quality Stabilization

Although the country is being flooded with anti-Quality Stabilization editorials, and although hardly a day goes by in Congress that an attack on the measure is not made, all indications are that the bill will be passed if Willard Simmons receives the support he keeps asking of you. That we are in sight of success, after so many unsuccessful, discouraging years and such large expenditures of money and time, is no doubt due to the wisdom of our Congressional friends. By excluding from H.R. 3669 drugs, medicines and devices requiring a prescription-order, Congressman Harris saved Quality Stabilization from being destroyed by the drug price hysteria that has raged these last four years. Fellow pharmacist Senator Hubert Humphrey likewise went to bat to save Quality Stabilization from the Congressional casualty list when, at a June 5 public hearing, he recommended that drugs be excluded from his own measure, Senate Bill 774.

Such unselfish actions, such common sense, have brought Quality Stabilization closer to enactment than ever before. More important, by clearly delineating the difference between a pharmacist's professional services and the commodities he employs, Quality Stabilization will help the profession of pharmacy and us individually. Striving as we all are to be full-time health professionals and to have rewarding and successful pharmacy practices, the public and the courts must be made to see that the pharmacists render a professional health service, and are not merely middlemen in the flow of commodities. Quality Stabilization with drugs excluded will help make "front-end" merchandise self-supporting and eliminate the need for it to be subsidized by the "back-end."

With or without Quality Stabilization, we will still have the problem of prescription services being used as loss leaders. The other day I saw a full-page advertisement in the Louisville **Courier-Journal** which included auto batteries, children's coats, wall paint, razor blades and tires. The feature of the advertisement, however, was the store's "Discount Priced Pharmacy!" That portion contained the usual misleading statement about savings of up to seventy percent on prescription medication. It emphasized that "prescriptions are filled" exactly as the physician orders by state licensed, experienced pharmacists using only the finest, freshest pharmaceuticals.

I don't know the pharmacists who are lending their licenses to the prostitution of our profession in this manner, but I do not feel that they are entirely to blame for what they are doing. I feel that they may be personifying an underlying sickness in our profession. Rather than condemn these men, we may ask why it is that chains, supers and grocers are able to lure and bribe them away from community pharmacies with high salary incentives and promises of security. We may well ask why these outfits are able to lure pharmacists with promises of being able to practice pharmacy eight hours a day in a clean, modern environment. This is a problem that will never be solved by legislation. It can only be solved by education, the building of professional esprit de corps, and most important, organized, probing research and analysis of the profession itself.

I hope NARD will support such research, which APhA is conducting for the improvement of the profession. Many of you are participating in the APhA project to determine the role of the pharmacy as a community health information center. The United States Public Health Service was sufficiently

interested in this project to assist APhA with a $100,000 grant, which has been further supported by grants from E. R. Squibb and Sons, and Smith Kline & French Laboratories.

Health Professions Educational Assistance Act

Just last month we saw an example of how successful cooperation between APhA and NARD can be. I am referring to Congress's passage of H.R. 12, the Health Professions Educational Assistance Act. That measure, again introduced in the House by pharmacy's friend, Oren Harris, authorizes Federal funds for pharmacy college construction. We all know that nothing is more important to our profession's future than that our pharmacy students have facilities in which to learn the sciences and how to be successful health practitioners. We can all be proud of the effort made that day when Calvin Berger of APhA and Joseph Cohen of NARD testified before Senator Lister Hill on H.R. 12. In his testimony, Cal Berger drew the praise of Senator Hill for the best presentation for pharmacy he had ever heard, thus helping Joe Cohen when he testified after Cal Berger. That's teamwork.

While there are provisions in H.R. 12 for assistance to pharmacy colleges, proof of need will have to be established before our colleges will materially benefit from this legislation. As you know, the recently completed Public Health Service Manpower Survey of Pharmacy gave us an indication of our manpower resources and utilization. It showed that we owners are a minority in American pharmacy, the division being sixty percent employee pharmacists and forty percent owners, and it showed that ninety-six percent of all pharmacists are in community practice.

Future Trends

I have no doubt that community pharmacy will continue to be the dominant practice in the future, though the form it takes may change considerably. I am sure that many of us here today could not afford to start the kind of pharmacies we now own. Even if we could raise the working capital, many locations would not be available to us. Shopping centers prefer to lease to chains; and in medical centers, some physicians reserve locations for their own pharmacies.

If we want to reverse the trend toward fewer and fewer owners, we must aggressively explore new forms of pharmacy practice. That is why APhA is so encouraged by those pharmacists who are successfully concentrating on streamlined, specialty practices adaptable to any environment and time.

As you know, Dr. Apple, in speech after speech, has been urging pharmacists to join together to strengthen professionalism, to work together to serve the public health by providing health information, professional service and community service. Dr. Apple has pointed out repeatedly that our professional services must provide the economic basis for our professional existence.

In one of the most forceful presentations I have ever heard, Dr. Apple told the AMA Board of Trustees and the AMA Judicial Council that American medicine has a responsibility to provide the kind of cooperation which will help pharmacy achieve a sound economic existence. He pointed out that the ownership of pharmacies by physicians, and the dispensing of drugs by physicians, undermine pharmacy's economic foundation.

Some have tried to interpret Dr. Apple's remarks as calling for the death of 30,000 pharmacies. An honest analysis is that he is fighting for the survival of 30,000 pharmacies. Dr. Apple, and every pharmacist who is interested in pharmacy as a profession, recognizes that the life blood of every pharmacy is its prescription and professional services. I am confident that there is not a pharmacist in this room who wouldn't be willing to give up all sales of unrelated merchandise tomorrow if he had the opportunity to practice and prosper solely as a health professional.

Organizational Unity

As I said earlier, there is much that we pharmacists and our organizations have in common. There are many joint efforts we participate in. It follows, then, that there can also be formal unity of organizations. In Miami, Frank Lobraico called this growing organizational unity "federation." In Michigan, we call it affiliation — the logical, natural uniting of pharmacists and their organizations into a local-state-national structure of strength and democratic action.

The uniting of pharmacists and their organ-

izations is not new. There were the apothecary guilds of Europe. The first national uniting of pharmacists in America brought the foundation of the American Pharmaceutical Association in 1852. There was the organization of our very own NARD, growing out of the APhA. In 1912 APhA took the first step toward a unified profession with the creation of the House of Delegates. The House was from the very beginning, and remains today, a truly democratic body in which state associations comprise over seventy percent of House membership, and national specialty organizations, another seven percent.

In 1915 a second step was taken, calling for an affiliated or federated structure. Dean Wulling of Minnesota, then President of the American Conference on Pharmaceutical Faculties, called for pharmaceutical associations to unite into a "strong federation, each preserving its own identity." By 1918, a specific proposal for necessary by-law amendments, and a combined dues structure, was approved and submitted to the respective state associations. But pharmacy was not ready, apparently, and the unity movement floundered because of jealousies, inadequate communications and even a fear that professionalism might be suffocated by trade interests.

In this day of emerging nations and conflicting ideologies, we see again and again the validity of the statement that even an army cannot hold back an idea whose time has come. The desire of pharmacists to unite into an unbreakable chain of local-state-national professional societies can never be destroyed.

We see unity all about us today. There is our own United States, which even includes far off Alaska and Hawaii; there is the United Nations; and, again closer to home, our community United Funds. This is the age of interdependence and unity. Our very own National Association of Retail Druggists symbolizes affiliation. Affiliated with the NARD are state, district, county and city groups. Our convention city host, the Chicago Retail Druggists Association, for example, is but one of many groups in which joint membership is required with NARD.

Thus, the NARD has and enjoys affiliated strength. It follows, then, that what is good for owners — and their specialty organization, the NARD — will also be good for all pharmacists and their national professional society, the APhA.

We Michigan pharmacists are proving that it is good. As you know, Michigan was the first state association to affiliate with the APhA. We reorganized from a store membership to an individual pharmacist membership and suffered no hardship. All 26 local associations have adopted new by-laws and all are affiliated with MSPA, including the Metropolitan Detroit Pharmaceutical Association, formerly known as the Detroit Retail Druggists Association. Specialty organizations of pharmacists, like the Michigan Society of Hospital Pharmacists, also have affiliated.

Local-MSPA-APhA affiliation has brought Michigan pharmacists new prestige and new strength. The same advances are being made in the other states that have voted to affiliate with APhA — Delaware, Virginia, Wisconsin, Iowa and Pennsylvania. Counting these states, nearly half of all the state pharmaceutical associations in the country are either studying APhA affiliation or have already voted to affiliate. Truly, America's pharmacists are on the march toward united, professional strength.

When Michigan pharmacists began talking of affiliation, there were any number of predictions that affiliation would fail. During the first year of local-MSPA-APhA affiliation, many said that it would never work. Even now, in its second successful year, there are still such predictions. I guess we can just expect them to continue year after affiliated year for the next 50 years.

Another prediction, especially displeasing to me as a NARD member, is that the NARD will be hurt by local-state-APhA affiliation. At first, I brushed such foolish talk aside, but it has kept up and I decided to ask the man who would know best, our own Executive Secretary Willard Simmons. The opportunity came up just a few weeks ago right here in Chicago when Willard, Frank Moudry, Bill Apple and I were discussing some of pharmacy's problems and the need to get more pharmacists to support all of their organizations.

"Willard," I said, "has APhA affiliation

hurt NARD in Michigan?" And Willard answered: "Bob, I personally don't think it has."

Willard went on to say that he knew not everyone felt the same way, but as far as he was concerned, Michigan was still one of the best and strongest NARD states in the country. My good friend, the late John McKeighan of Flint, Michigan, the President of NARD in 1955 and a member of APhA for most of his life, predicted that this would be the case. I just wish John were here with us today to tell you why he supported Michigan affiliation with APhA and why he believed it would benefit APhA and NARD as well as the state association itself.

As I said earlier, this is the age of unity and interdependence. No one can go it alone any longer. We must all work together — specialty and professional organizations — for the advancement of pharmacy. The affiliation with APhA of state professional associations, which exist to represent all pharmacists in their areas regardless of their employment status, is natural and advantageous to all of pharmacy. The productive and successful existence of specialty organizations for hospital pharmacists, pharmacy owners, educators and others is natural and advantageous to all of pharmacy. United together, working together within the structure of the American Pharmaceutical Association, there is nothing that pharmacy cannot accomplish in the years ahead.

Self-Treatment

But, we need not wait for time to bring success to joint endeavors. There is a job we can begin to do right now. It is a job that will not only improve and safeguard the public health, but one that will bring new prestige and honor to pharmacy. I am talking about the area of self-treatment.

As health professionals, we pharmacists are appalled at the risks the public takes with its health, and even its life, through the indiscriminate use of proprietary preparations. Day in and day out, we pharmacists see example after example of unwise self-treatment by the public. It is frightening to realize that a torrent of potent proprietary preparations are being made available to the public from gondolas in supermarkets, gas stations and restaurants throughout the country.

This cannot go on. The lay public needs the personal guidance of pharmacists in the acquisition and use of products for self-treatment. As President Kennedy said in his National Pharmacy Week telegram to me, "The very nature of today's potent new drugs requires constant professional surveillance over their distribution and use."

I am sure that Dr. Robert P. Fischelis, for example, could tell us much about the work of the APhA Committee on Proprietary Medicines prior to the enactment of the 1938 Food, Drug and Cosmetic Act. Dr. Fischelis could also tell us about the work of the APhA-sponsored Committee on Federal Food, Drug and Cosmetic Law Problems prior to the enactment of the 1951 Durham-Humphrey Amendment. NARD had four representatives on this APhA Committee and actively participated in its deliberations until NARD decided to go it alone. We have carefully reviewed the record of this period and can find no reference to a NARD proposal for a legal class of drugs for self-treatment which would be available personally from pharmacists.

I don't wish to leave the impression that APhA made such a recommendation during this period. It is true that Dr. Fischelis, working through the National Drug Trade Conference, subsequently did endeavor to work out a classification involving non-prescribed drugs but Proprietary Association opposition prevented final agreement.

Since its founding in 1852, the APhA has concerned itself with protecting the public in the area of self-treatment. Because it is APhA's position that the public is best served when all drugs are available from a pharmacist, we have been most interested in a World Health Organization proposal dating back to 1956. The World Health study group stressed that no drug should be made available to the public without some supervision. The study group considered it desirable that the sale of all drugs and pharmaceutical preparations should be made by pharmacists. It is recognized that many pharmaceutical preparations which cannot be classified as poisons, in the usually accepted sense, can nevertheless be dangerous without expert advice and supervision.

The World Health group, therefore, proposed that pharmaceutical preparations in-

clude the category "sale restricted to pharmacists" as well as the category "available on prescription only."

The 1951 Durham-Humphrey Amendment to the Food, Drug, and Cosmetic Act in effect resulted in the establishment of two categories of marketable drugs in the United States. The first is that group of drugs that must be prescribed by a duly authorized medical practitioner. The second category consists of those drugs which the individual citizen may employ for self-treatment.

Now it is obvious that all drugs cannot be placed on prescription-order only status. Any effort to make all drugs available only upon prescription-order would be unwise, unworkable and unnecessary. History itself shows us that self-treatment — or autotherapy — is an integral and necessary part of civilized life. Reputable proprietary preparations exist as an adjunct to professional medical care, and they are used by some individuals to maintain themselves in their usual condition of health.

Entirely aside from possible psychic and physical benefit, such preparations prevent available health resources from being swamped by patients with real or imaginary symptoms which may not require attention by a medical practitioner. But it must be remembered that these same preparations when used indiscriminately can result in people ignoring symptoms which require prompt attention by a medical practitioner.

There are times when patients innocently jeopardize their health or life by taking proprietary preparations that are incompatible with the prescription medication which has been ordered by their physician. By having a personal pharmacist, and obtaining all drugs, including proprietary preparations, from him, the lay person can avoid this hazard.

It follows that as long as there is self-treatment, there will be a pharmaceutical industry that will manufacture agents for such use. In America, that industry is the proprietary manufacturers. It is to the credit of that industry that its members have sought to improve their products and have shown serious concern about the claims made for the products. These manufacturers have also sought to attain the widest possible distribution of their products. This is the usual business method in the United States. In this regard, although the profession of pharmacy may not quarrel with the proprietary industry for what it has done in the tradition of business, we believe the industry should not quarrel with us for voicing the conscience and concern of our profession in a matter of health.

Health Consultants

Until the public has a better understanding of the difference between prescribed drugs and proprietary preparations, and between proprietary preparations and nostrums, they will be spending their money, and needlessly risking their health.

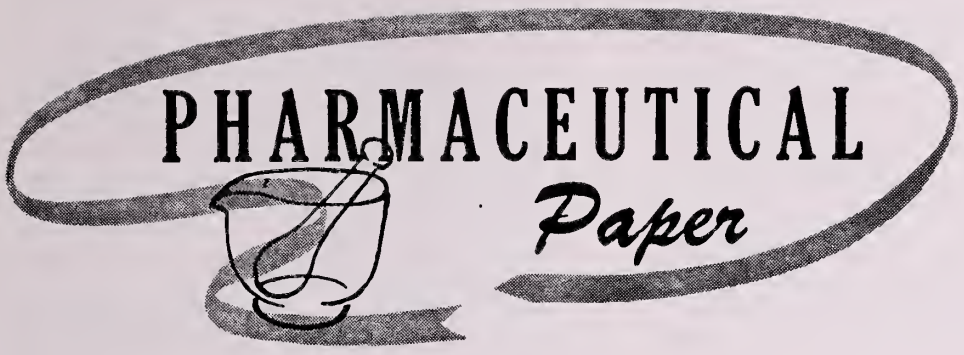
The layman needs to be taught to recognize the approximate boundaries of his own therapeutic competence, and the dangers inherent in attempting to exceed them. He cannot do this entirely on his own. The consumer must be provided with that degree of professional supervision and guidance in autotherapy that will mean he will wisely and safely use the proprietary preparations available to him. We can only wonder how many disease symptoms are being masked by continued self-treatment today, or how many work days are lost, or by how much the country's medical care cost figure is made bigger through misguided and unguided autotherapy.

Pharmacists in many states are endeavoring to serve as health consultants to the public at the point of purchase of proprietary preparations. Proprietary manufacturers, for economic reasons, have opposed this safeguard because they see it — and any state regulation requiring it — as hampering the unlimited distribution of their products.

Certain drugstore owners view requiring the distribution of proprietary preparations personally by pharmacists as an economic disadvantage, for certainly professional counseling of the patient will take the time of the pharmacist. This, however, is a contribution the profession should and must make in the public interest.

The American Pharmaceutical Association has taken the lead in helping pharmacists to bring their professional education and experience to bear nationally on autotherapy. APhA has already presented detailed recom-

(Continued on Page 58)



PHARMACY AT SOUTH DAKOTA STATE COLLEGE

by
Guilford C. Gross, Ph.D.*
Brookings, South Dakota

Historical Synopsis**

The earliest mention of pharmacy at what is now South Dakota State College, appears in the institution's catalogue of 1887-88. In this catalogue, pharmacy was offered as an "industrial" along with such subjects as botany, chemistry, cooking, dairying, etc., and every student was expected to take one "industrial" each term of his course.

The two-year course in pharmacy was established in 1888-89 as a branch of the Chemistry Department, and was "designed to fit young men and women for the business of druggists." Eleven students enrolled in the first class (1888-89) five of whom, in 1890, became the first class to "graduate."

The catalogue of 1893-94 authorized the awarding of the Ph.G. (pharmacy graduate) degree to those students completing the course in pharmacy. Five students, comprising the class of 1895, were the first to receive this degree. This is the first class recognized by the Office of Admissions and Records as graduating in pharmacy. In this class was Bower T. Whitehead who later (1896) became professor of pharmacy.

D. F. Jones, who held the Ph.G. degree from Northwestern University, was named professor of pharmacy in 1895 and, as such, became the first head of the newly created Department of Pharmacy. He resigned in 1896 and was succeeded by Professor Whitehead who continued in that position until his death in 1917.

Professor Whitehead was, in turn, succeeded by Mr. E. R. Serles (later Dr. Serles) who was named acting professor of pharmacy, serving in this capacity until his entry into the military service in 1918. Upon his return, in 1919, he was named professor of pharmacy and, in 1923, when the college was reorganized into five instructional divisions, he became dean of the Division of Pharmacy, a position he held until his resignation in 1940 to accept the deanship of the College of Pharmacy of the University of Illinois.

A four-year course in pharmacy was offered as early as 1898 but a majority of the early students terminated their college course with the Ph.G. degree. The two-year course was discontinued with the fall term, 1924. The three-year course, leading to the Ph.C. (pharmaceutical chemist) degree, which was first offered in 1918, continued until 1930 when it was replaced by a mandatory four-year course leading to the B.S. (bachelor of science) degree. This, in turn, was discon-

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For a detailed history, the interested reader is referred to an article "A History of Pharmacy at South Dakota State College" by Clark T. Eidsmoe, which appeared in the October, 1958, issue of **This Journal, and from which this synopsis is largely taken.

tinued with the fall term, 1960, when the five-year course became mandatory for all accredited colleges of pharmacy.

Following the resignation of Dean Serles, Dr. Floyd J. LeBlanc was named acting dean, and later, dean, a position that he holds at the present time. Dean LeBlanc, who received his undergraduate training at South Dakota State College, has been a member of the pharmacy faculty since 1922 and was professor and head of the Department of Pharmaceutical Chemistry prior to his present appointment.

Facilities and Staff

The Division of Pharmacy occupies approximately 18,000 square feet on the first floor of the Administration Building on the South Dakota State College campus. The most recent expansion was completed in 1954 with the addition of modern laboratories, office and research space. Much new equipment has been acquired, both for instructional and research use, such that, today, the facilities and equipment are of the most modern type. With the completion of the new science building, scheduled for use beginning with the fall term, 1964, additional space will become available. The building, which will be occupied jointly with the Department of Chemistry, will house the entire Department of Pharmaceutical Chemistry, providing additional laboratory and research facilities. A joint pharmacy-chemistry library will be a useful and convenient feature of the new structure.

The staff of the division is comprised of nine members (see accompanying photograph) headed by Dean Floyd J. LeBlanc. Professor Clark T. Eidsmoe, a member of the staff since 1929, heads the Department of Pharmacy, a position that he has held since 1940. Dr. Guilford C. Gross, professor and head of the Department of Pharmacology, received his initial appointment in 1940 and his present title in 1952. LeBlanc, Eidsmoe and Gross all received their undergraduate training at South Dakota State College.

Dr. Kenneth Redman, professor and head of the Department of Pharmacognosy, was initially appointed in 1951 and has held his present title since 1953. Dr. Harold S. Bailey was appointed to the staff in 1951 and was made professor of pharmaceutical chemistry



Pharmacy Faculty, 1963-64. Standing, left to right: Dr. Harold S. Bailey, Dr. Gerald Bruno, Dean F. J. LeBlanc and Dr. Robert Knott. Seated, left to right: Dr. Kenneth Redman, Miss Lola Schuman, Dr. Gary Omodt, Prof. Clark T. Eidsmoe and Dr. Guilford C. Gross.

in 1958. In 1961, he was appointed dean of academic affairs for the college and presently serves the division on a part-time basis as director of a dental-pharmacy research project. Dr. Gary Omodt, associate professor of pharmaceutical chemistry, was named to the staff in 1958 and received his present appointment in 1963.

Newly appointed to the staff, in 1963, are Dr. Robert Knott, associate professor of pharmacy and Dr. Gerald Bruno, assistant professor of pharmaceutical chemistry. Also appointed in 1963 is Miss Lola Schuman, a 1963 graduate of the Division of Pharmacy, who serves as a research technician on the dental-pharmacy research project.

Academic Program

The Division of Pharmacy at State College is one of 76 accredited institutions by the American Council on Pharmaceutical Education. It is one of two divisions of pharmacy in the country, the others being classified as schools or colleges.

The academic instruction of the division is organized into four departments: Pharmacy, Pharmacology, Pharmaceutical Chemistry and Pharmacognosy. Undergraduate majors are not offered by the individual departments, only the bachelor of science degree in pharmacy being conferred upon those who successfully complete the course of instruction.

The five-year program of instruction is presently in effect, the four-year program

having been discontinued with the graduating class of 1963. The extended program was initiated, after considerable nation-wide study, to provide the pharmacy graduate with a broader educational background, particularly in the humanities. A few schools in the nation offer six-year courses of study.

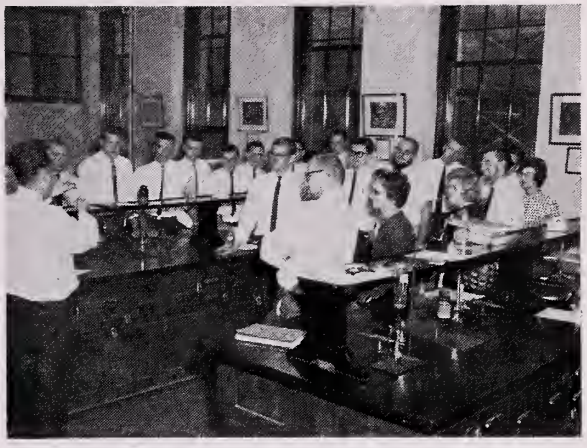
The division has adopted, as its academic policy of instruction, what is known as the "two-three" plan which means that two years of the five-year program are devoted to pre-professional work and three years to professional study. In accordance with accreditation stipulations, three years of professional study is the minimum period permitted. Other options used by schools of pharmacy in the nation are the "one-four" plan and the completely integrated program or "zero-five" plan.

The semester system of instruction was instituted with the fall term, 1963, and it is now the system used by all state-supported institutions of higher education in South Dakota.

Enrollment

Throughout the years, there has been a steady increase in the enrollment in the division although periodic dips have occurred from time to time, particularly during periods of national emergency. Present enrollment (fall term, 1963) numbers 218 which represents an increase of ten over that of a year ago. Of this number, 38 students are women. The gradual increase in the number of women students entering pharmacy has been one of the particular changes noted over the years and the current entering group of 18 freshman women represents an all-time high.

Because of the transition to the five-year program which will be completed with the fall term, 1964, there are presently only four classes of students enrolled, representing the first four years of instruction. By classes, enrollment is as follows: First year, 81 (18 women); second year, 62 (14 women); third year, 46 (1 woman); fourth year, 29 (4 women). There will be no graduating class in June, 1964. It is anticipated that the fall term of 1964 will show a marked increase in the total enrollment since, with that term, all five classes will be represented.



Dr. Robert Knott, associate professor of pharmacy, explains a technique to a class of fourth-year pharmacy students.

Graduates

A total of 1381 students have been graduated from the division since the first official graduating class of five received the two-year Ph.G. degree in 1895. The average graduating class has been approximately 50 over the last ten years.

Of the approximately 650 registered pharmacists serving the state, more than 80 per cent are graduates of the Division of Pharmacy. It is probable that a State graduate owns or works in almost every retail drug store in South Dakota. In addition, State graduates serve in every state in the union, including Hawaii and Alaska.

Approximately 85 per cent of State's pharmacy graduates enter retail pharmacy; others have specialized in research, pharmaceutical manufacturing, education and journalism, chemistry, dentistry and medicine.

In addition to Dean LeBlanc, there are four State graduates who presently are heads of pharmacy schools in the nation: Dr. Noel E. Foss, B.S. 1929, University of Maryland; Dr. L. David Hiner, B.S. 1929, University of Utah; Dr. Byrl Benton, B.S. 1936, Drake University; and Dr. Willis Brewer, B.S. 1942, University of Arizona. The late Dr. Serles, State's first dean of pharmacy, also served as dean of pharmacy at the University of Illinois from 1940 until his death in 1957.

Almost half of the degrees granted by the division, 643, have been bachelor of science degrees. The master of science degree is also offered by the several departments in the division, and 13 such degrees have been awarded to date.

Acknowledgment

The author wishes to acknowledge the services of Dean F. J. LeBlanc and Professors Clark T. Eidsmoe and Kenneth Redman of the pharmacy faculty of South Dakota State College for supplying certain data used in this article.

A PHARMACY OWNER SPEAKS—

(Continued from Page 54)

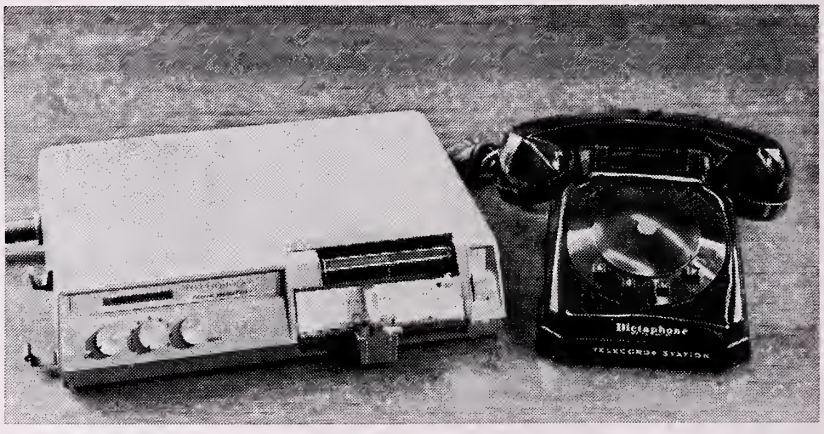
mendations in this matter to Health, Education and Welfare Secretary Anthony J. Celebrezze and to Senator Humphrey in his capacity as Chairman of the Senate Subcommittee on Reorganization and International Organizations. I have also asked Dr. Apple to have this important subject included in the program of the National Congress of Pharmacy and Medicine.

We were very greatly encouraged by Willard Simmons' announcement on September 24 that the NARD is interested in this program. We are further encouraged by the fact that last Sunday the National Conference of State Pharmaceutical Association Secretaries adopted a resolution supporting legislation for the reclassification of drugs under law "so as to provide a category of drugs for self-treatment which are available personally from a pharmacist."

In conclusion, let me say again how pleased I am as a member of the NARD, and as President of the APhA, to have been invited to be with you today. Certainly, in these troublesome times, it is vital that we pharmacists exchange views and come to understand each other. It is equally vital that we see where team work and cooperative action between our organizations can be further encouraged. That is why I have particularly mentioned the APhA-NARD work on physician-ownership, Quality Stabilization, health professions educational assistance, and autotherapy. I have also sought to show that if affiliation, or federation, is good for pharmacy owners and NARD, then it is equally good for pharmacists and APhA.

Understanding each other, working together to advance our profession and the public health, there is nothing that we pharmacists cannot accomplish.

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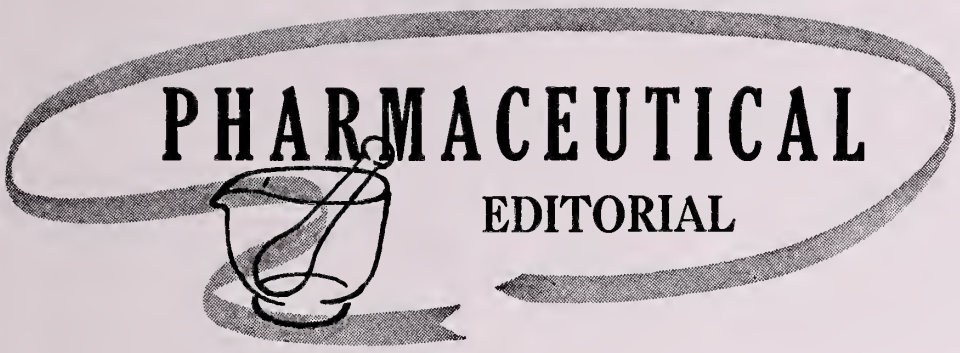


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TO REFILL OR NOT TO REFILL

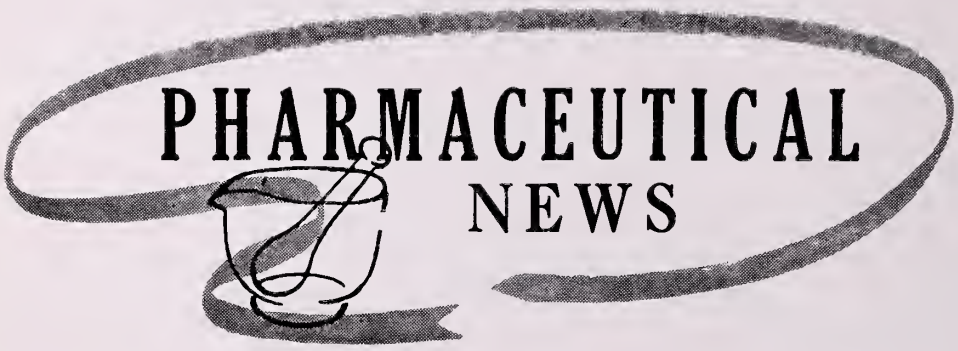
"To Refill or Not to Refill" is the title of an article on prescription renewals appearing in the October issue of the **Journal of the Florida Medical Association.** Written by B. S. Rogers, F.A.C.A., a Jacksonville pharmacist who is President Elect of the American College of Apothecaries, the article focuses attention on this very serious interprofessional problem.

Physicians and pharmacists share the burden of seeing to it that the patient's legitimate medical requirements are met with minimum inconvenience, Mr. Rogers stated. The physician must be continuously aware of the amount and length of time a medication is being utilized. The pharmacist has identical professional obligations in this area and is bound to observe Federal and State laws which require the physician's prescription order or renewal authorization before medication can be dispensed.

"In addition there is the problem of professional liability. Court cases have been decided in favor of patients when proper care and procedures were not followed by either physician or pharmacist."

Refill instructions can be specified by the prescriber on his original prescription order but should the physician fail to make any notation, "the pharmacist is placed in a difficult position when faced with the patient who seeks to have a prescription renewed," Mr. Rogers observed. In this case the pharmacist must call the physician for his oral renewal authorization. Some physicians fail to acknowledge or return telephoned requests by pharmacists or limit the hours during which they will accept such calls. These procedures comprise a severe handicap when as a result the pharmacist may not fulfill the legitimate medication needs of patients. "Resentment develops and the patients question whether the health professions are genuinely concerned about them," Mr. Rogers pointed out. "Mutual respect, understanding and cooperation are necessary," he stated. "By specifying renewal instructions on the prescription or by graciously accepting telephonic communications, the physician can avoid inconvenience to himself, his patient and the pharmacist and avoid placing the pharmacist in a compromising position. He can insure that the patient's medication needs are properly satisfied and the necessary safeguards are provided at the least possible cost. Better public and interprofessional understanding must ensue from such cooperative practice and better patient care must necessarily result."

Mr. Rogers' article was published in the journal at the invitation of the Florida Medical Association Committee on Pharmacy. Reprints of "To Refill or Not to Refill" are available from the American College of Apothecaries, Hamilton Court Hotel, 39th and Chestnut Streets, Philadelphia 4, Pennsylvania.



APhA OFFICERS FOR 1964-65

J. Curtis Nottingham, practicing pharmacist and a leader in Virginia pharmacy is the new president-elect of the American Pharmaceutical Association.

The position of first vice president-elect went to **Thomas J. Macek,** immediate past-chairman of the APhA Scientific Section and Director of Pharmaceutical Research and Development for Merck, Sharp and Dohme Research Laboratories. Practicing pharmacist **James W. Alexander** of Minneapolis, Minnesota, and president of the Northwest Minnesota APhA Chapter, was elected second vice president-elect.

Councilors-elect include Seattle, Washington, practicing pharmacist **Robert E. Lee;** NABP secretary, **Fred T. Mahaffey;** and Ohio State University College of Pharmacy Dean, **Lloyd M. Parks.**

These officers were elected in a mail ballot by active APhA members in good standing.

The newly elected officers will be installed at the conclusion of the APhA Annual Meeting in New York City, the week of August 2, 1964.

RAPID BARBITURATE IDENTITY TEST DEVELOPED

A simple, rapid method of identifying, either alone or in combination, five of the more common barbiturates using thin-layer chromatography has been developed by three pharmaceutical scientists from the University of Illinois Medical Center. The method promises to be extremely useful for toxicological purposes.

Current barbiturate identification procedures have several shortcomings, particularly when there is a need to determine the presence of barbiturates as the causative agent of coma in hospital patients or death in medical-legal cases from samples of blood or urine. Based on work conducted in conjunction with toxicological studies in the Coroner's Laboratories of Cook County, Illinois, John A. Petzold, Walter J. R. Camp, and Ernst R. Kirch report the successful application of their procedure to blood and urine samples in the November issue of the **Journal of Pharmaceutical Sciences.**

The authors show that with this procedure it is possible to establish the presence of secobarbital, amobarbital, pentobarbital, phenobarbital, and diallylbarbituric acid — either when present individually or with all five in a single combination.

APhA—USPHS PHARMACY EVALUATION STUDY UNDERWAY

The American Pharmaceutical Association - United States Public Health Service pharmacy evaluation study is underway across the nation.

On November 1st 360 pharmacies across the nation began displaying a variety of

health information brochures as part of the national pilot project to evaluate the community pharmacy as a source of family health information. Operating under a U. S. Public Health Service grant, the study project will run through June, 1964, at which time the American Pharmaceutical Association will examine the results to determine whether the concept of pharmacy health information centers is a workable one and whether the program can be expanded to include all pharmacies in the country.

More than thirty national professional and voluntary health agencies are contributing hundreds of thousands of pieces of literature which deal with major community health problems of interest to the general public. Each month, 15 to 20 different publications will be displayed in the prescription laboratories of the participating pharmacies. These pharmacies were randomly selected by National Analysts from their National Probability Sample. Their selection represents a cross section of the country and types of pharmacies. Large and small towns in all parts of the country are involved as are large, mass merchandising establishments, community pharmacies and apothecary pharmacies.

Pharmacy patron interviews were begun on October 8 prior to the actual display of publications. Another group of pharmacy patrons will be interviewed at the conclusion of the program. This before and after interview technique is being used to determine changes in attitudes and opinions concerning the idea of the pharmacy as a health information center.

The entire project is being administered by the American Pharmaceutical Association, with National Analysts, Inc., of Philadelphia, conducting the research and evaluation. E. R. Squibb & Sons and Smith, Kline & French Laboratories have also contributed financial assistance to the project.

PHARMACEUTICAL SCIENCES PROJECT HANDBOOK NOW AVAILABLE

A new publication to assist high school students in developing pharmacy research projects is now available.

The booklet entitled "Pharmaceutical Science Project Handbook," offers projects in pharmacy, pharmaceutical chemistry, pharmacognosy and pharmacology as guides to young people who wish to conduct high school science projects. The booklet was prepared by the American Association of Colleges of Pharmacy Committee on Recruitment Aids, and published by the American Pharmaceutical Association Foundation for the National Advisory Commission on Careers in Pharmacy.

The 32-page booklet is one that pharmacists will be able to use in counseling students who seek advice for project ideas and source information for classroom experiments and research papers in high schools.

The Pharmaceutical Sciences Project Handbook is available at 25 cents per copy, and in quantity at $15.-00 per hundred. Orders should be sent with remittance to Careers, American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D. C., 20037.

FDA REORGANIZED

A reorganization of the Food and Drug Administration was recently announced by Anthony J. Celebrezze, Secretary of Health, Education, and Welfare.

The reorganization adopts salient features from recommendations of the Second Citizens Advisory Committee on the Food and Drug Administration, which made its report in October, 1962.

An important feature of the reorganization is the appointment of a National Advisory Council to the Food and Drug Administration comprised of representative citizens under the chairmanship of the Commissioner of Food and Drugs. It will advise the Administration on national needs and the effectiveness of program policies.

A new Associate Commissioner, a scientist, will give leadership from the Office of the Commissioner to the programs and functions having to do with medicine, science and research.

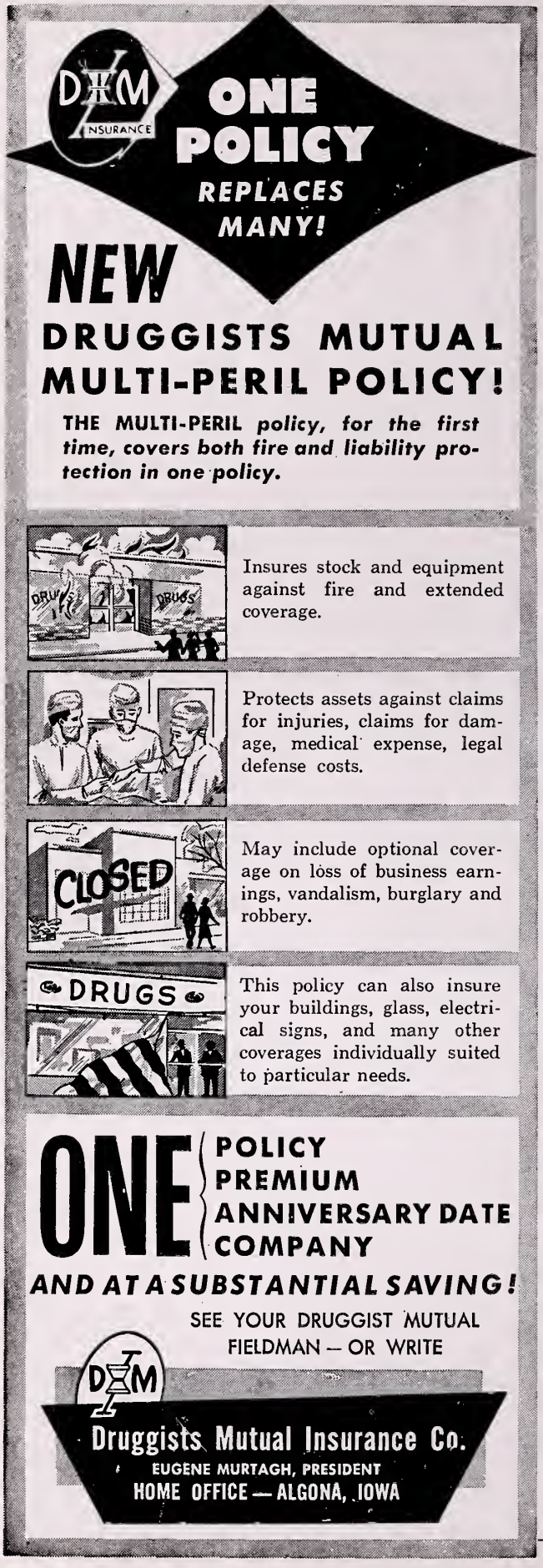
Two new bureaus with scientific activities are established — a Bureau of Scientific Research, supporting FDA's basic mission of

consumer protection, and a Bureau of Scientific Standards and Evaluation, which will handle safety clearance functions in regard to pesticides, food additives and colors, and develop scientific data to be used in setting standards and tolerances. These Bureaus replace the Bureau of Biological and Physical Sciences.

No change is contemplated in the present Bureau of Medicine, which has recently been reorganized to handle new responsibilities under the Kefauver-Harris Drug Amendments of 1962.

Enforcement activities will be consolidated in a single Bureau of Regulatory Compliance replacing in part the Bureau of Field Administration and the Bureau of Enforcement, which have had divided enforcement responsibilities.

Educational functions of the Food and Drug Administration are emphasized in the creation of a new Bureau of Education and Voluntary Compliance. This will include the Division of Advisory Opinions, formerly in the Bureau of Enforcement, which answers industry inquiries on compliance problems. The bureau also includes the Industry Education Branch, and the Consumer Education Branch and Consumer Inquiries Section from the Division of Public Information, and the Consumer Consultant Program in the Office of the Commissioner. Press and public information services will be carried on by an Office of Public Information.





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SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.

CM-9694



The insomniac



The tense, nervous patient



The heart-disease patient



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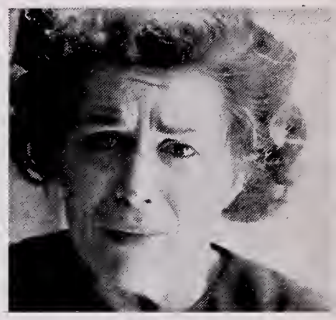
The girl with dermatosis



Tension headache



The woman in menopause



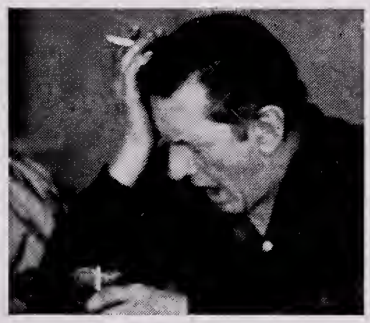
Anxious depression



Premenstrual tension



The agitated senile patient



The alcoholic



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*Donnelly, J.: A.M.A. Arch. Environmental Health 6:697, June, 1963

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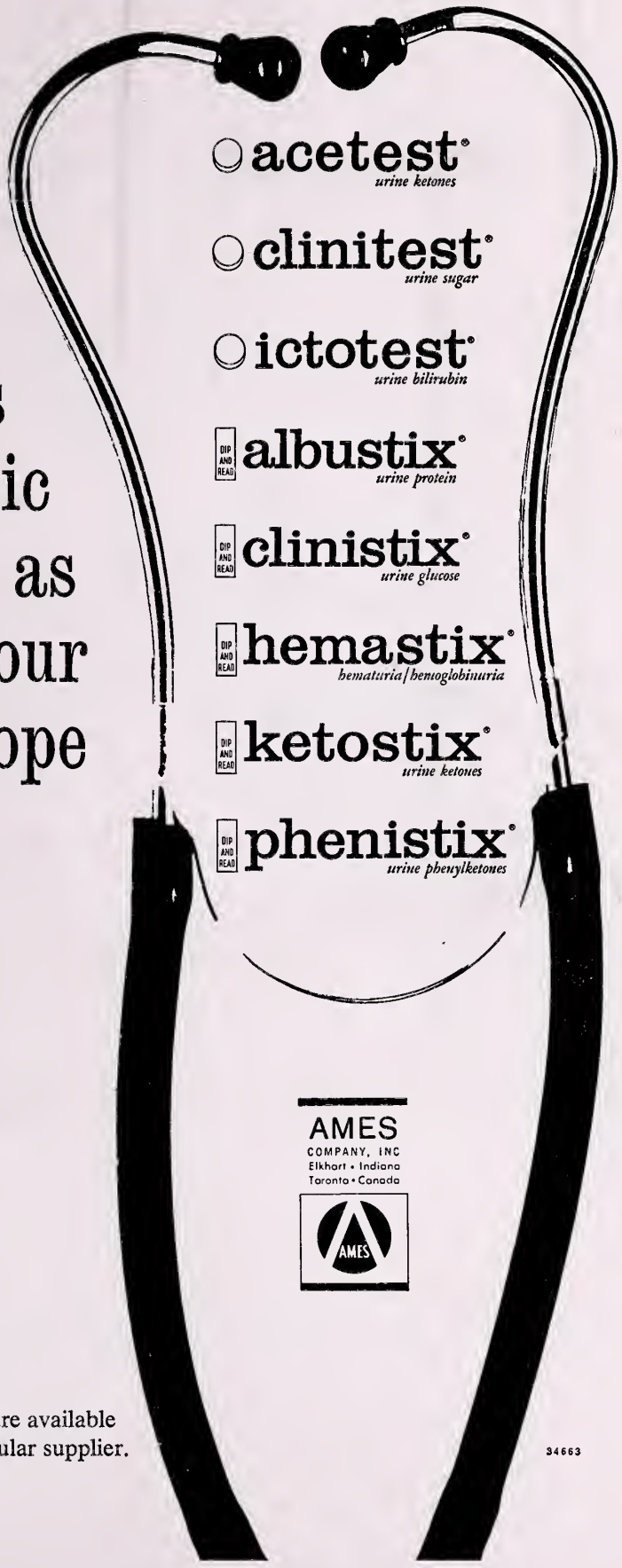
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In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment. Caution should be exercised in prescribing any therapeutic agent for pregnant patients. Supplied—Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

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